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Updates

Mississippi commissioner indicted in BC/BS scandal

JACKSON, Miss.—A federal grand jury has indicted Mississippi Insurance Commissioner George R. Dale on charges of extortion and fraud related to campaign contributions from Blue Cross & Blue Shield of Mississippi and other insurers.

One of two indictments, leveling extortion charges, names Mr. Dale, the state's insurance commissioner since 1976; Charles Pace, a former deputy commissioner; and Aaron J. Johnston, former CEO of the Mississippi Blue Cross plan.

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Minimal insurance cover for San Juan oil spill

By JUDY GREENWALD

SAN JUAN, Puerto Rico—The operator of the barge that spilled more than 900,000 gallons of oil into the ocean along San Juan's main beach area has $10 million in pollution liability coverage, but that won't be nearly enough.

With cleanup costs already exceeding $10 million, the U.S. Coast Guard officially assumed financial responsibility for the operation as of 6 a.m. Friday. It was unclear what steps, if any, the Coast Guard would take to recover its expenses.

Early last week, officials made progress in cleaning up the oil. But pounding surf on Thursday morning caused more oil to spill from the barge Morris J. Berman.

"The water's still black. It's been black since the first day," said a spokeswoman for the Caribe Hilton, a beachfront hotel. However, it and other nearby luxury hotels remain open.

The spill, which occurred when a tow line connected to a tugboat snapped, is only the latest in a long series of environmental problems associated with the New Jersey family of Evelyn Berman Frank, who owned and operated the barge and operated the tug boat as well.

The barge's $10 million of pollution coverage was underwritten by Water Quality Insurance Syndicate of New York, which is owned by 17 U.S. insurers.

New England Marine Services is named as the owner on the policy and the Bunker Group of Puerto Rico is listed as the operator, although New England Marine Services is registered with the Coast Guard as both owner and operator.

New England Marine is controlled by one or more Frank family members, according to Steven J. Madonna, a New Jersey state environmental prosecutor. Bunker is believed to be one of the 40 or more corporations also owned by the Frank family.

Generally, under the Oil Pollution Act of 1990, the owner of a barge the size of the Morris J. Berman would face a maximum of

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Merger would create HMO giant

By JOANNE WOJCIK

FOUNTAIN VALLEY, Calif.—FHP International Corp.'s proposed acquisition of TakeCare Inc.—the largest HMO merger ever—will create a powerful new regional force in managed care.

By joining forces, the two health maintenance organizations will become the second-largest California-based HMO and the third largest—excluding enrollment in point-of-service programs—in the nation with about 1.6 million members.

Ranking HMOs with their POS enrollment, the merged firm would be No. 6 nationally.

The acquisition, announced last week, would allow Fountain Valley-based FHP, whose operations are concentrated in Southern California, to expand into Northern California and Colorado, where it had recently been trying to establish itself.

Concord-based TakeCare, which has 742,000 members, is already strong in both regions.

The move also will allow FHP, the nation's largest Medicare risk contractor, to increase its penetration of this market outside of Southern California.

This move comes amid a flurry of health care mergers fueled in large part by the expectation that larger companies that offer a wide range of services over a wide area will fare better under health reform.

It is the third major consolidation proposed in California since President Clinton unveiled his reform proposal.

Woodland Hills-based Health Net Inc., with 915,000 California members, last fall announced

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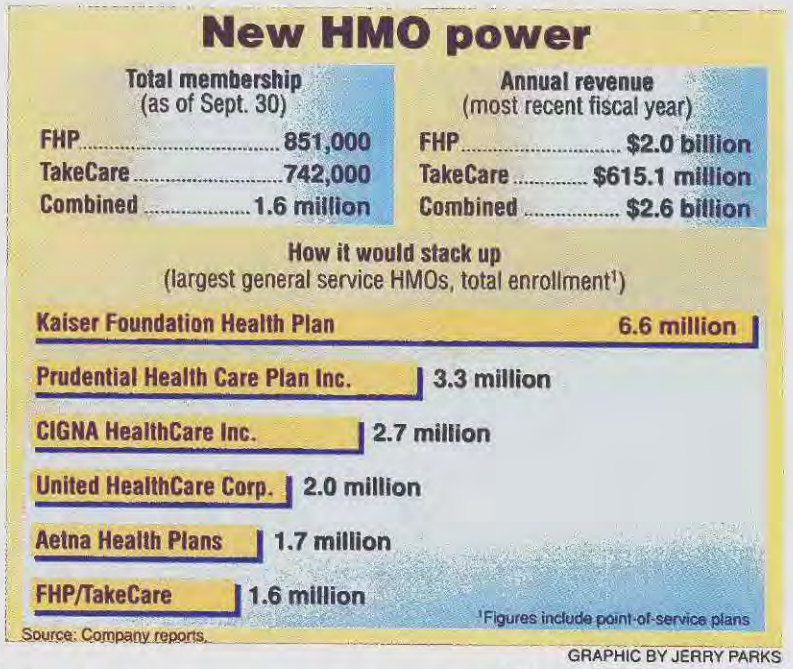

GRAPHIC BY JERRY PARKS

HCFA reaps savings, complaints

By JERRY GEISEL

WASHINGTON—Federal officials say a massive data collection and billing program is on target to save the government hundreds of millions of dollars in claims that employer health plans—not Medicare—should have paid on behalf of older workers and other beneficiaries.

Officials of the Health Care Financing Administration, the federal agency that administers the Medicare program, say the so-called Data Match program has saved the government more than $200 million during its first year.

But only about $70 million of that savings represents back payments that the HCFA actually has received for claims that employer plans should have paid during the mid- and late 1980s.

A big portion of the HCFA's savings calculations include future estimated savings from the better records the government and its Medicare contractors are compiling on older workers. That has reduced the likelihood of Medicare continuing to improperly pay claims for those workers, the agency says.

Some employer plan administrators, though, complain that anywhere between 40% and 50% of the bills that HCFA contractors are sending out involve claims they already paid.

In other cases, plan administrators say the bills are inflated.

Plan administrators also say that even after they have paid HCFA claims, they continue to receive bills for the claim.

"We've gotten a second demand letter after we've received canceled checks," Linda Meyer, vp-compliance and quality assurance at Harden & Co. Insurance Services Inc., a Concord, Calif.-based third-party claims administrator.

HCFA officials acknowledge that bills sent out by their contractors—typically insurance companies—often are inaccurate. Mistakes are inevitable because it is not always possible for HCFA to tell if an employer plan was responsible for an entire bill incurred by an older worker.

HCFA officials say some of the problems with multiple billing requests after payments have been made have been caused by TPAs that submitted checks not accompanied by summary information sheets.

These developments are taking place one year after HCFA first began to send out demand letters to administrators of employer health care plans.

The demand letters are part of a HCFA project to ensure that the government achieves the savings it intended when legislators passed a series of laws in the 1980s to shift to employer plans some of the health care costs previously paid by Medicare.

Under those laws, employer

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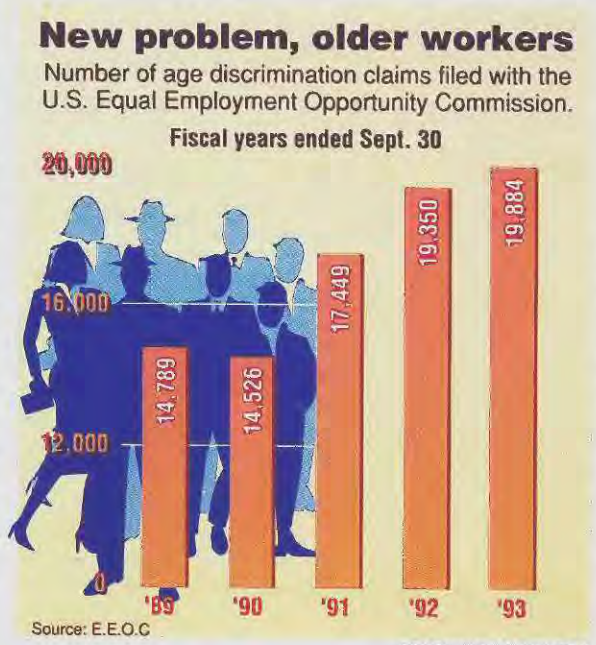

GRAPHIC BY CHRIS ROY

Age-related suits increase

Rising jury awards force employers to pay attention

By SARA MARLEY

Employers increasingly feeling the one-two punch of a rise in age discrimination claims and larger awards by juries in these cases.

Widespread layoffs and the recent recession are largely responsible for the rise in claims. Age discrimination claims filed with the Equal Employment Opportunity Commission jumped 34% to 19,884 in 1993 from 14,789 in 1989.

Even though discrimination damages are sometimes insured, risk managers are often left out of corporate discussions of layoffs, several experts say. That could change as the problem grows bigger, they add.

Juries seem especially sympathetic to victims of age bias, a fact that has made employers search for ways to minimize their liability exposure.

"One of the problems unique to age discrimination is that in the latest round of layoffs, middle managers have been squeezed out," said Cheryl Blackwell Bryson, employment practice leader at Chicago law firm Rivkin, Radler & Kremer. "Many of the group most affected are in the protected age group."

Discrimination against people 40 years old and older is generally prohibited by the Age Discrimination in Employment Act of 1967. There is no maximum age for protection.

Age bias suits are fast becoming a fact of corporate life. "If a plant is closing and you drop 400 or 500 people at once, you can de-

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Updates

Mississippi regulator indicted

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The indictment alleges that Mr. Dale and Mr. Pace removed a department examiner critical of Blue Cross management and deleted critical comments from a final exam report on the insurer. In return, Mr. Dale received $2,500 in campaign contributions from Blue Cross and its employees, and Mr. Pace was hired by Blue Cross at more than twice his state salary, the indictment charges.

The indictment supersedes an October 1993 indictment that named Mr. Pace and Mr. Johnston but not Mr. Dale (*BI*, Jan. 3).

Mr. Dale was also named last week in a separate conspiracy and fraud indictment charging him with receiving more than $100,000 in campaign contributions from companies he regulated. Contributions were made in amounts intended to avoid campaign reporting requirements, and Mr. Dale omitted money he received on yearly reports filed with the state ethics commission, the indictment alleges.

Mr. Dale and Mr. Pace pleaded not guilty last Thursday.

If convicted on all charges, Mr. Dale faces a maximum of 55 years in jail and $1.25 million in fines. Mr. Pace and Mr. Johnston face up to 40 years and $500,000 in fines.

Wellness savings shown

ANN ARBOR, Mich.—Wellness programs can lower employers' health care costs significantly over the long term if enough high-risk employees participate, the University of Michigan says in its nine-year evaluation of Steelcase Inc.'s program.

Steelcase, which self-funds its health care program, said employers of a similar size could expect to save $20 million in health care costs over three years if all high-risk employees adopt healthy lifestyles.

About half, or 4,000, of the Grand Rapids, Mich.-based furniture maker's employees participated in the study, which began in 1985 and is set to conclude next year. The study is the nation's longest-running evaluation of its kind, the university said.

Study results, all of which have been converted into 1993 dollars, show that high-risk employees who adopted healthy lifestyles in 1988 reduced their average annual health claims costs by 53.5%. Those costs dropped to $537 per individual for the 1988-1990 period from $1,155 for the 1985-1987 period.

Average claim costs for high-risk employees who did not change their lifestyles rose 45% to $1,677 during the same periods.

Punitive award review faulted

PASADENA, Calif.—Juries in California cannot simply use a mathematical formula to calculate an appropriate ratio between punitive and compensatory damages, a federal appellate court has ruled.

The Jan. 11 decision by the 9th U.S. Circuit Court of Appeals in *Donald R. Boyle and Alpha One Productions vs. Lorimar Productions et al.* found that a lower court failed to follow California standards for reviewing whether punitive damages violate due process. The lower court erred by concluding in its review that the punitive damages had a "relationship" to the compensatory damages because the punitive award was "exactly 20 times" the compensatory award. The appeals court also faulted the lower court's consideration of the defendant's gross revenues rather than net revenues in its review.

The jury awarded Mr. Boyle $180,000 in compensatory damages and $3.6 million in punitive damages on breach of contract and fraud claims arising out of the parties' agreement to transfer Mr. Boyle's rights to a treatment, or rough draft, for a television series to Lorimar.

The case is now remanded to the lower court to reconsider the appropriateness of the punitive award.

Asbestos settlement approved

NEW YORK—The Manville Personal Injury Settlement Trust will pay three groups of asbestos claimants a reduced percentage of their pre-1990 settlements or judgments under a settlement approved last week by the 2nd U.S. Circuit Court of Appeals.

Under the settlement, the trust will pay the groups, consisting of nearly 12,000 claimants, 60% to 80% of their original claims value, totaling $349 million. The three groups are a class of claimants from Texas, a class from Virginia and a class of other individuals suffering asbestos-related injuries. The groups had either settled with the trust or won judgments against it before the trust stopped paying claims in 1990, due to insufficient funds and litigation over the trust's legality.

Patricia Houser, the trust's executive director, said that reducing the value of earlier settlements and judgments will make about $137 million available for future settlements. "If plaintiffs' attorneys not party to this settlement do not appeal (it) to the Supreme Court, we can finally move on paying claims to others."

Since 1990, the trust has been prevented from making payment to any claimant but the most severely injured individuals.

Shares returned to pensioners

LONDON—Lehman Bros. International has agreed to return approximately $40 million in securities to pension funds operated by the late publishing mogul Robert Maxwell's Mirror Group.

This is the second piece of welcome news this month for Mirror Group pensioners, who are owed a total of 200 million pounds ($299.6 million) of the 450 million pounds ($674.1 million) in pension funds.

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Errors & Omissions

- The name of Tom Fellows, a partner with Robinson & Wood in San Jose, Calif., was misspelled in the Jan. 10 issue.

Conditional DES damages set for non-cancer injuries

By MICHAEL SCHACHNER

NEW YORK—In an unusual legal proceeding, a New York jury says 11 women are entitled to $42.3 million in damages if they can prove that in utero exposure to the anti-miscarriage drug DES caused them to develop reproductive problems and, in a few cases, cancer.

In a unique case that is being described in entirely different ways by plaintiffs and defense attorneys, a New York state court jury was instructed by Judge Ira Gammerman to assume that diethylstilbestrol, or DES, did cause the injuries. Given that assumption, the jury ruled that the women deserve compensatory damages ranging from $10 million to $12 million for cancer, and $125,000 to $2 million for fertility problems alone.

Attorneys for the women say the conditional damage award is vital for women suffering from a number of DES-related ailments because it's the first time a jury has awarded any damages for DES injuries other than cancer.

They also contend that the ruling should stick because the next steps in the case—proving causation and liability—will not be terribly difficult since medical experts have found a clear connection between cancer, fertility problems and DES.

"It's precedent setting and a

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Outcomes research lags: Study

Plans question value of data

By JERRY GEISEL

At a time when health care reform advocates say patients should have more information on the results of different medical treatments, only a small percentage of managed care organizations and providers are heavily involved in outcomes research.

A new survey released this week by A. Foster Higgins & Co. Inc. reports that only 24% of managed care plans and provider groups are either extremely or very actively involved in outcomes research.

On the other hand, 76% of respondents—which included 102 health maintenance organizations and preferred provider organizations as well as 127 provider groups—either are not at all active or only somewhat active in outcomes research.

Consultants say it is quite surprising—given the strong interest in Congress and the Clinton administration in requiring health care plans to give patients more information on quality performance—that providers aren't doing more in the area of outcomes research.

"Providers and health plans have a long way to go in this area," said Glenn Meister, a principal in Foster Higgins' Los Ange-

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Comp reform advances

California implementation rules finalized

By LOUISE KERTESZ

LOS ANGELES—Final regulations implementing California's sweeping workers compensation reform clear the way for the state's ambitious effort to trim billions of dollars from its massive workers comp system.

Key aspects of the final regulations pertain to: the certification of managed care organizations that will treat injured workers; restrictions on medical-legal evaluations; and limits on some vocational rehabilitation expenditures.

According to the state's workers comp administrator, earlier drafts of the rules have been revised to address the concerns of employers, insurers and health care providers.

In issuing those earlier drafts and soliciting input at public hearings last fall, "Our goal was to try and get these things done as quickly as possible, so we didn't cross every 't' and dot every 'i,'" said Casey Young, administrative director of the state's workers compensation division. "Then we took the heat, got some good testimony" and revised the regulations, he said (*BI*, Dec. 6, 1993).

"The process works," said Mr. Young, adding "we got a lot of kudos on the changes we made" in revisions prior to the final regulations. "My sense is we made it a

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Lloyd's offer gets rough reception

By STACY SHAPIRO and ADRIAN LADBURY

Lloyd's stays tough on settlement offer despite opposition

LONDON—Lloyd's of London's 900 million pound ($1.35 billion) offer to end litigation with loss-plagued members appears to be dead in the water.

Lloyd's has said that about 70% of 22,800 members who were offered the settlement must individually accept it by the extended deadline of Feb. 14 for the settlement to be unconditional (*BI*, Jan. 3).

However, at least eight members action groups have formally advised their members to reject the offer. These groups comprise the majority of members on syndicates that account for as much as 66%, or 591.5 million pounds ($889.3 million) of Lloyd's total settlement.

But the fate of Lloyd's offer ultimately depends on the meetings this week of two of the eight groups, Gooda Walker Action Group and Feltrim Names Assn. The combined membership of these syndicates accounts for about 46% of Lloyd's total offer, though not all of the members belong to the action groups.

Despite the threat of failure, Lloyd's will not alter the offer in any way, especially the amount and the requirement that members drop the right to sue Lloyd's agents, Lloyd's Chief Executive Peter Middleton said last Friday. The offer

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Inside

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- Property/casualty insurers must look to the future and set realistic prices based on that view, this week's editorial says. **PAGE 8**
- The Employee Benefits Information Resource Guide describes available information on products and services for employee benefit managers. **PAGE 16**
- Personnel policies should mandate the use of alternative dispute resolution as a first step in handling wrongful termination claims, Thomas F. Byrne says in Perspectives. **PAGE 23**
- Insured losses as high as $103.6 million from the Australian brush fires won't affect reinsurance markets greatly. **PAGE 31**

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Cuomo critical of Clinton plan impact on state

Public health plan would be scrapped

By MICHAEL SCHACHNER

ALBANY, N.Y.—New York Gov. Mario Cuomo is urging the state's congressional representatives to push for changes in the Clinton health care reform package so that successful public employee health care plans like New York's would not have to be dismantled.

In a letter distributed to all state and local government employees in New York earlier this month, Gov. Cuomo commends President Clinton for his efforts to improve the nation's ailing health care system but also condemns key elements of the plan.

A GAO report says health insurer regulation is inconsistent. .....Page 4

AP/Wide World Photo

Gov. Mario Cuomo

Specifically, the letter points out that the Clinton plan would only allow large private-sector employers to opt out of regional health care purchasing alliances and offer their own benefits packages.

If public-sector plans like the New York State Health Insurance Plan, which provides comprehensive, community-rated health benefits to more than 400,000 public employees and their dependents, are broken down and transferred to purchasing alliances, state employees would certainly lose some of the benefits they now have, the letter states.

In addition, the letter points out that the Clinton plan seeks to cap private employers' costs for basic health benefits at 7.9% of payroll with the federal government picking up costs above that. However, public plans would not be subject to the cap. As a result, taxes paid by public employees would wind up subsidizing the private sector, with public employees reaping no benefits from the cap, Gov. Cuomo says in his letter.

"I am proud of our current health care benefits and committed to protecting them in every way possible. By working together with combined strength, we can make clear to Washington the inequities within the administration's current proposal and ensure New York state has the flexibility and authority to preserve in our system what works," the letter says.

Gov. Cuomo makes it clear that he will implore New York's congressional delegation to seek changes in the proposal.

NYSHIP is one of the "largest

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Few insurers gambling on riverboat casinos

Risk managers challenged by risks, unique coverages

By GAVIN SOUTER

Legions of boat operators and a few insurers are hoping to hit the jackpot by taking a chance on recently licensed riverboat gambling vessels.

In addition to their entertainment value for gamblers, the new vessels are presenting new challenges to risk managers and underwriters.

Large volumes of customers intent on leaving the floating casinos with more money than when they boarded and potentially large crew liabilities make risk managers and underwriters cautious.

And risk managers used to dealing with property/casualty underwriters are finding that marine insurance is often a very different business.

Until loss histories are more established for the riverboat casino industry, several insurers are content to let others test the odds before they take a seat at the table.

The President Riverboat Casino navigates the Mississippi River.

Gambling licenses for riverboat casinos were first granted in Iowa in April 1991. Since then, Illinois, Louisiana and Mississippi have licensed riverboat casinos. Gambling boats are expected to begin operating in other states like Indiana, Missouri and West Virginia soon. And, some predict, floating casinos will be allowed in most states by the end of the century.

There are about 30 to 35 riverboat casinos currently operating, and 110 "are on the drawing board," said David Merki, a manager in the marine department of Johnson & Higgins in Cincinnati.

"Gaming vessels are now one of the biggest issues (in marine insurance)," said Darby Duryea, senior vp in J&H's marine department in New York. The value of vessels in use ranges from $5 million to $20 million each, though some now being built may be worth up to $100 million, Mr. Duryea said.

The largest vessels can carry up to 1,500 people, and some of the boats that are operating on the Mississippi River are 600 feet long, Mr. Merki said.

Insurance for the vessels is written largely by marine underwriters on a combined hull and liability basis. The hull coverage would cover damage to the vessel and equipment on board. The liability coverage for marine risks, referred to as protection and indemnity coverage, covers passenger and crew liability as well as other third-party liability risks.

Despite the potential for profit from insuring riverboats, only six insurers in the United States and even fewer in the London market so far are willing to take on the vessels' liability risks, brokers say.

Low deductibles, inadequate premiums and the lack of established loss figures are the main deterrents for underwriters, said Mark Jones, protection and indemnity underwriter at Sphere Drake Insurance P.L.C. in London. Sphere Drake is closely watching riverboat casino risks but currently writes only a small amount of coverage for

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Executives address industry concerns

Clinton plan 'extreme': Enthoven

By MARK A. HOFMANN

NEW YORK—The best thing Congress can do when it reviews President Clinton's health care legislation is to erase the whole 1,300-plus pages and replace it with a managed competition-based proposal sponsored by a bipartisan coalition of legislators, says the intellectual architect of managed competition.

Alain Enthoven, Marriner S. Eccles Professor of Public and Private Management in Stanford University's Graduate School of Business, says he doesn't think that the president's plan has much to do with managed competition. In fact, Mr. Enthoven branded the Clinton plan as having the potential to become a "single-payer plan in Jackson Hole clothing."

Mr. Enthoven is also a key member of the Jackson Hole Group that produced the managed competition blueprint that Mr. Clinton, as a candidate, seemed to embrace as the basis for health care reform.

Mr. Enthoven offered his assessment of health care reform during an address to the industry conference of the American Insurance Assn., the Insurance Information Institute and the Insurance Services Office Inc. in New York last week. He later participated in a panel discussion on the impact of health care reform on the property/casualty insurance industry, most notably workers compensation.

After capturing the attention of an already friendly audience by noting that both his father and grandfather had worked in the property/casualty insurance business, Mr. Enthoven said that the health insurance industry is not without blame for the predicament in which it finds itself. And, he said, property/casualty insurers could learn from health insurers' problems.

For example, health insurers "stonewalled" for years over the need for moderate market reforms, and when the insurers finally put forth reform proposals, they were small and weak, he said.

As a result, the administration is now pushing "extreme reforms" that basically reduce health care to a public utility, according to Mr. Enthoven.

Most health insurers were also very slow to innovate, and as a result lost much of their traditional market to self-insurers and HMOs, he said.

The property/casualty industry should learn from these mistakes, he said. For example, he said property/casualty insurers need to try to make the market work "visibly" better to address consumer complaints that lead to such punitive measures as California's Proposition 103. Mr. Enthoven made clear that he vehemently opposed

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Andrew prepared industry for next hit

By GAVIN SOUTER

NEW YORK—While the insurance industry faced more than $15 billion in losses from Hurricane Andrew, one benefit of the storm is that the price tag is likely to be lower if a similar hurricane strikes, a panel of insurance executives concedes.

Insurers learned many lessons in disaster recovery as a result of dealing with the hurricane's devastating losses in 1992, they said.

And by being better prepared and more aware of the difficulties they face in the future, insurers should be able to work more efficiently in the aftermath of another hurricane, the panelists suggested.

Still, they added, insurers and state regulators have a ways to go before the problem of financing hurricane losses is solved.

The sheer magnitude of potential hurricane damages, which could far exceed Andrew depending on where a storm hits, is forcing states and the federal government to consider new mechanisms to meet the costs of rebuilding after a hurricane strikes.

"The first impact I felt from Hurricane Andrew was a visit from my president saying, 'it's no longer hypothetical; it's reality,' " said Harold D. Covey, executive vp of State Farm Fire & Casualty Co. in Bloomington, Ill.

He was among the panelists addressing catastrophes during a session at the joint annual meetings of the American Insurance Assn., Insurance Information Institute and Insurance Services Office Inc. in New York last week.

State Farm had 1,500 people in the area affected by Andrew to deal with 210,000 claims, he said.

And the impact of the disaster was not only felt in Florida because State Farm had to continue to service clients in the rest of the country at the same time, Mr. Covey said.

As a result of Hurricane Andrew, State Farm established a new disaster response program that was partially tested by Hurricane Emily in 1993, and the company is now better positioned to respond to another hurricane, he contends.

Previous experience with disasters helped some insurers prepare for Hurricane Andrew, said Fredric G. Marziano, president of Continental Insurance Cos. in New York.

The company had flown employees to the area to process the claims and were ready to go to work within hours of the hurricane hitting, he said.

"That is very different from how we responded to previous disasters," Mr. Marziano said.

And those employees flown in had been

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GAO raps health insurer regulation

By MEG FLETCHER

WASHINGTON—The quality of regulation of health insurers varies greatly from state to state, a new federal government report says.

There are "wide variations in the practices and procedures used to monitor insurer solvency, approve health insurance premium rates and policy forms and respond to consumer complaints," according to the report by the General Accounting Office.

However, the GAO stopped short of drawing any conclusions about states' ability to deal with proposed national health insurance reforms.

State officials rebut the report's conclusions and say it relied on outdated data in several instances.

Rep. Fortney H. "Pete" Stark, D-Calif., chairman of the Health Subcommittee of the House Ways and Means Committee, requested the report after investigations by congressional staff concluded that "lapses in regulatory oversight" contributed to the failure of a Blue Cross & Blue Shield plan in West Virginia and to the financial problems of Blues plans in Maryland and New York.

The GAO surveyed state insurance departments from May 1992 to May 1993. Investigators also visited seven insurance departments.

The study's major findings include:

• The average state insurance department devoted about 24% of its 1991 operating budget to regulating health insurers. However, by state, this commitment of resources ranged from a low of 4% in Hawaii to a high of 57% in Montana.

• Twenty-one states had at least one actuary on staff who works on health insurance matters, while 11 others had an actuary under contract. However, 14 states did not have a health insurance actuary either on staff or under contract.

• Regulators in the states visited believe that an insurer's financial situation should be reviewed at least annually. The total amount of time spent on each insurer financial review ranged from about one to 40 hours.

• Insurance departments typically conduct onsite examinations of health insurers every three to five years, which is "too infrequent" for regulators to detect solvency problems, the authors said.

• While all states review health insurance policy forms, few states require that first-time rates for health insurance be preapproved. Others did not approve them at all or allow them to be used subject to the department's veto.

• Most state insurance departments do market conduct examinations to review the health insurers' marketing, underwriting, rating and claims payment practices.

In response to the report, Rep. Stark said, "The GAO documents the failure of states to adequately investigate, audit and monitor private health insurance policies sold to consumers.

"In a number of states, there is virtually no consumer protection against unfair premium pricing practices, much less unscrupulous sales tactics," he said.

"The GAO casts doubt on the capacity of every one of the 50 states to successfully implement the long list of new obligations required under the administration's Health Security Act," the congressman added. "Relying on states to oversee all health plans—in the absence of strong federal standards and oversight—will be an unmitigated disaster for consumers."

Due to the report's "negative implications for a primary state role in health reform," federally established minimum standards and guidelines are essential for any national health care plan, said a spokesman for Rep. Stark.

The congressman favors such standards as well as a single-payer health insurance plan. He also has co-sponsored a bill that would expand the federal Medicare program to all citizens.

State officials criticized both the GAO report and Rep. Stark's observations.

The National Assn. of Insurance Commissioners questioned several points in the GAO's report and criticized it and previous GAO reports for unsupported conclusions, according to a letter accompanying the report.

"While we make no claim to perfection, we are doing our best to correct any shortcomings," NAIC President David J. Walsh wrote in a Jan. 12 letter to Rep. Stark.

"You seem to conclude that because the states are not perfect, they will be unable to protect insurance consumers under a reformed health care system," said Mr. Walsh, who also is Alaska's director of insurance. Following that reasoning, the federal government "should have little or no role in regulating financial institutions, given its performance in that field," he said.

The report "conveniently neglects" to mention the NAIC's longstanding call for congressional reform of the Employee Retirement Income Security Act to give state regulators—instead of the U.S. Department of Labor—the ability to regulate health care plans, Mr. Walsh said. The GAO itself reported that improper oversight of benefit plans has "victimized" more than 400,000 Americans, he said.

The GAO report also uses "embarrassingly outdated" information on the enactment of small-group health reforms by several states and on the success of the NAIC's accreditation program, he said.

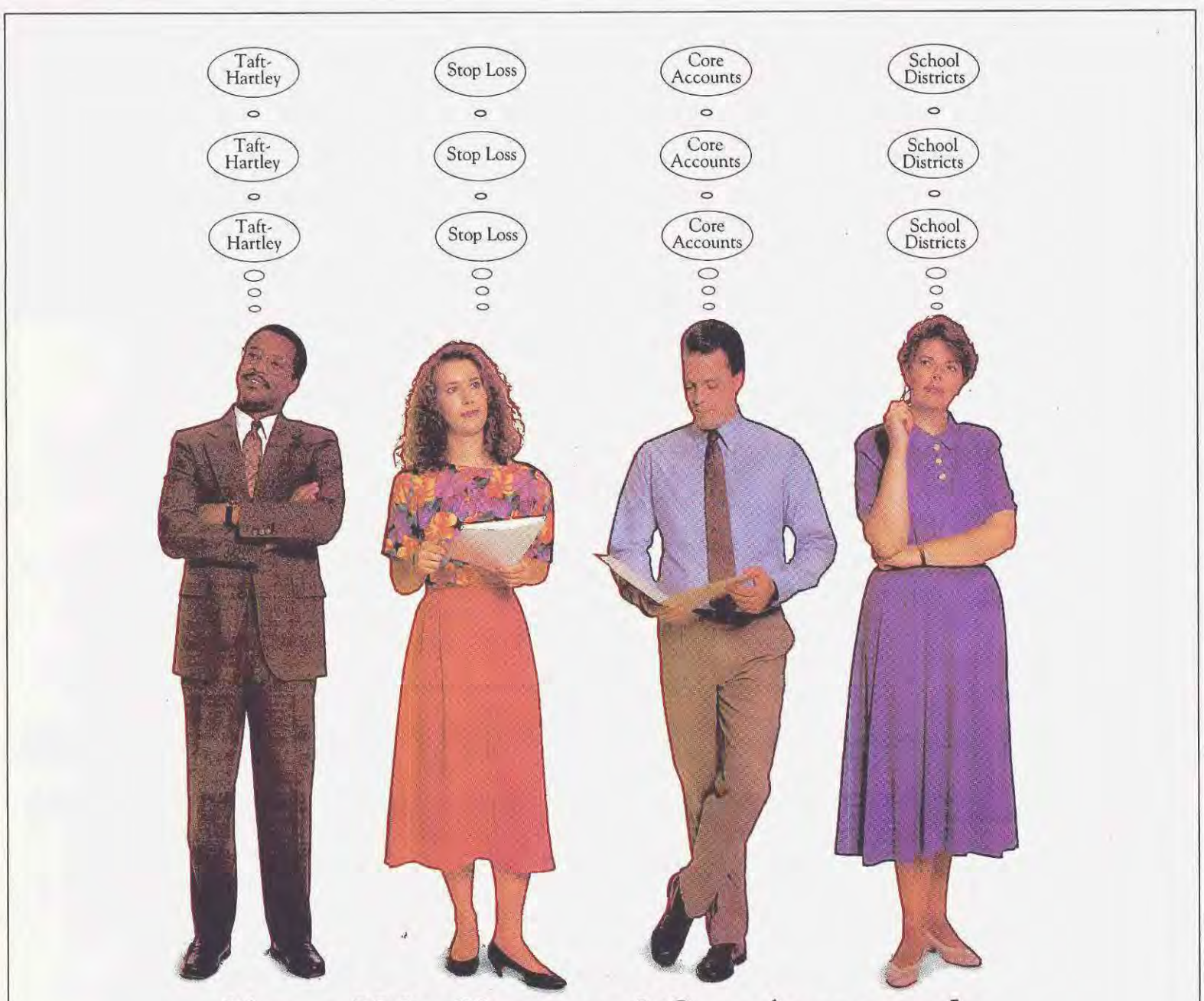
The report also fails to note several health reform initiatives the NAIC is currently working on, such as a risk-based capital formula that would apply to health insurers like BC/BS plans and health maintenance organizations, he added.

Health reform requires a national solution, but "it is important to keep in mind that the expertise offered by state regulators is part of that solution," Mr. Walsh said.

Representatives of two other state legislative organizations also voiced criticisms.

"There are a lot of people in state insurance departments that do a good job of responding to consumer complaints about health insurance; what Rep. Stark says does not do them justice," said Robert Mackin, executive director of the National Conference of Insurance Legislators.

"The National Conference of State Legislatures can't dispute the GAO's finding that there are variations among the states in their regulation of health insurance, but there is no indication that the federal government can do a better job," added Joy Johnson Wilson, director of the NCSL's Health Committee. BI



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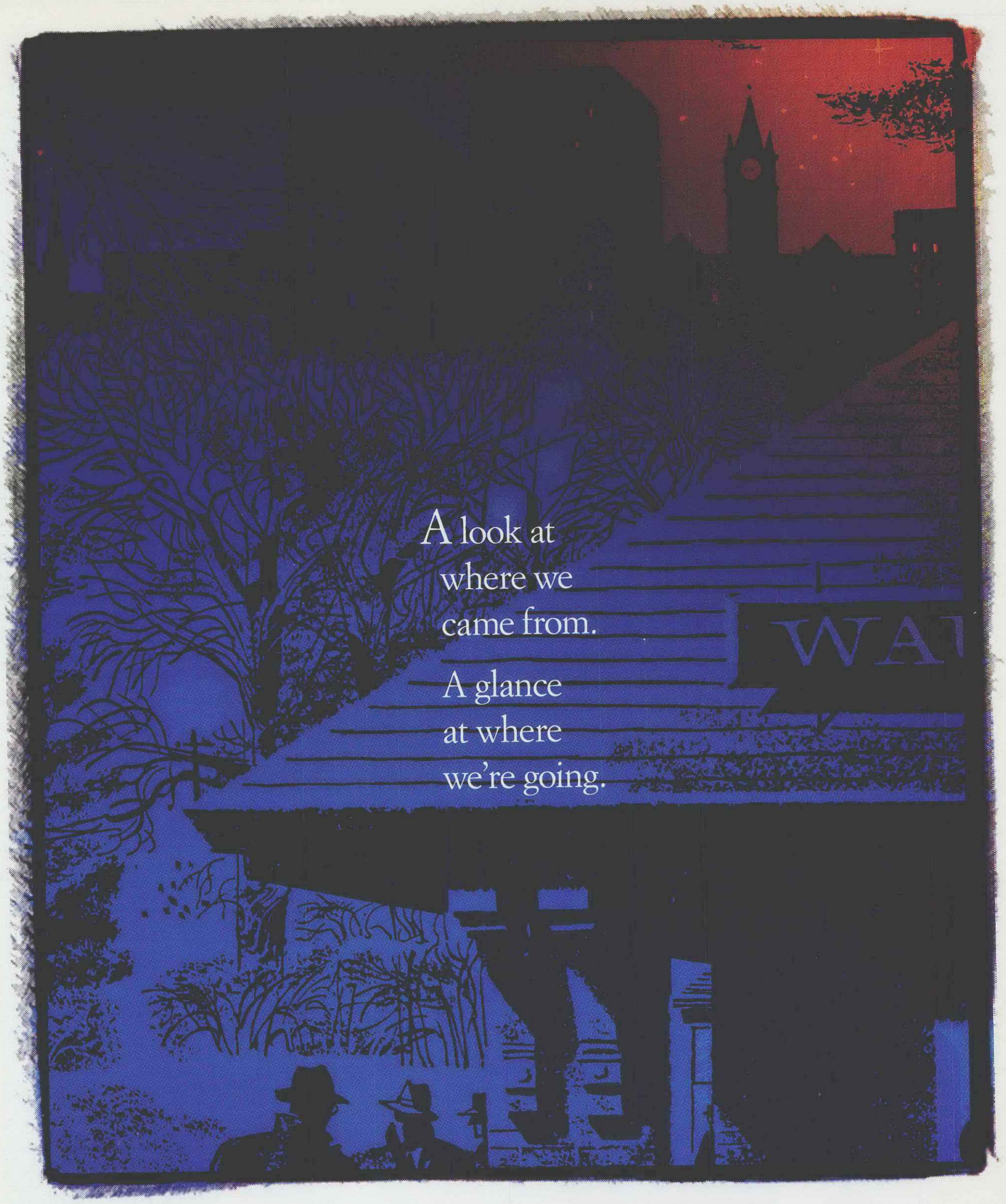

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Lloyd's made mistakes: Rowland

NEW YORK—Everybody at Lloyd's of London must accept some blame for the market's recruitment of members during the 1980s who were markedly less well-off than established members of Lloyd's, says David Rowland, chairman of Lloyd's.

"During the 1980s a lot of people joined Lloyd's because it was fashionable," Mr. Rowland said at the so-called All-Industry meeting in New York last week.

But when those people were faced with the huge losses that have hit Lloyd's of London over the past four years, they were not equipped to pay the losses as easily as their counterparts in the 1960s, when Lloyd's suffered huge losses on account of Hurricane Betsy, Mr. Rowland said.

And although all of the implications of unlimited liability are explained to members before they join, Lloyd's itself must accept some responsibility for recruiting members who are now strapped for funds, he said.

"We were all at fault. At Lloyd's we should have been more rigorous in the way that we looked at the underpinning of our society," Mr. Rowland said.

But despite the mistakes made in the market in the 1980s, Lloyd's members must still expect to pay the losses for which they are liable, Mr. Rowland insisted.

And those members seeking redress from Lloyd's of London should accept the settlement offer that has been made to members, Mr. Rowland said.

Lloyd's recently decided to extend its 900 million pound ($1.34 billion) settlement offer until Feb. 14.

—By Gavin Souter

Enthoven

Continued from page 3

Proposition 103 when it passed in 1988 and continues to do so today, saying he thinks it may violate the U.S. Constitution.

Property/casualty insurers also should rely more on preferred provider-like networks to provide cost-effective services such as repairing insured automobile damage, he said.

Mr. Enthoven went on to describe what he called "how the Clinton administration hijacked managed competition and turned it into socialized medicine."

He said that although the administration adopted much of the Jackson Hole recommendations, it failed to include a crucial one: a limit on the tax deduction for employer-provided health benefits. The administration also threatens to subject health care to price controls if unrealistic goals of controlling the rate of growth of health care costs are not met. As a result, the administration is setting up the market system to fail, he said.

He noted that the Jackson Hole Group advocated the creation of health care purchasing alliances for small businesses and individuals as a means of cost control. Mr. Enthoven added that, unlike some of his Republican friends, he insisted that participation in the alliances be mandatory, because voluntary participation would invite adverse selection.

But the Clinton plan would make alliances mandatory for larger businesses as well. But by holding that only employers with 5,000 or more employees be permitted to operate their own corporate alliances and that everyone else be forced into regional alliances, the Clinton plan virtually eliminates any role for the private sector. The plan boils down to a "huge federal power grab," said Mr. Enthoven.

Instead of endorsing the Clinton plan, Mr. Enthoven called on Congress to replace it with a moderate health care plan drafted by Reps. Jim Cooper, D-Tenn., and Fred Grandy, R-Iowa. The Cooper-Grandy bill, H.R. 3222, would allow states to set the maximum size of employers participating in its version of alliances anywhere between 100 and 500 employees, cap the tax deductibility of employer-provided benefits and replace Medicaid with a new federal program to provide coverage for the poor (*BI*, Oct. 11, 1993). The bill has garnered considerable bipartisan support.

Managed competition was 'hijacked' and Clinton 'turned it into socialized medicine,' says Alain Enthoven.

Mr. Enthoven also blasted suggestions that the workers compensation system and the medical component of automobile insurance be merged into a reformed health care system. The implementation problems are "immense," he said, and the need for workers comp experience rating as a means to encourage safe workplaces conflicts with the idea of community rating proposed by many health-care reformers.

When the panel discussion on the impact of health care reform on property/casualty insurance began a few minutes after Mr. Enthoven finished his address, it was more than evident that property/casualty insurers shared the scholar's concerns.

"We really would prefer that Washington ignore workers comp," said David A. Kocher, chairman of the AIA's special committee of the board on workers compensation.

Gerald L. Maatman, chairman and chief executive officer of Kemper National Insurance Cos. in Long Grove, Ill., said he doesn't think that federal officials understand how worker comp insurers hold down costs by providing loss-control advice and industrial hygiene services. If the Clinton health care plan is adopted as is, insurers and employers would lose much of their ability to manage the indemnity side of workers comp, he said.

"It's opening the door to the eventual federalization of the workers compensation system," said Mr. Maatman. He added that he thought the Clinton plan could

Continued on page 12

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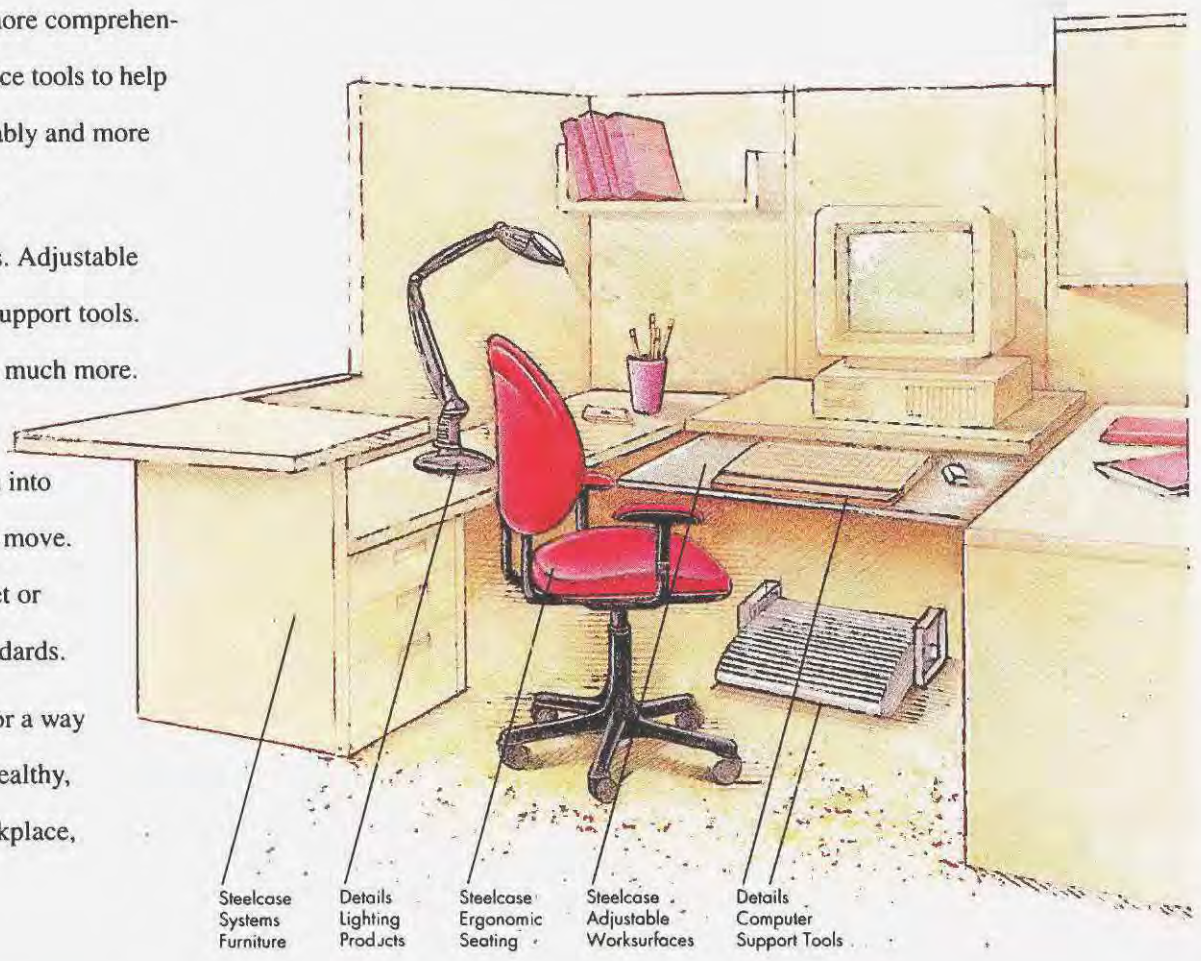

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Opinions

Facing financial realities

THE CHIEF EXECUTIVES of some of the nation's largest property/casualty insurance and reinsurance companies gathered last week in New York for the annual industry conference that kicks off the new year. The speeches and panel discussions (see stories starting on page 3) touched on issues of dire importance to the industry: the effect health care reform will have on property/casualty insurers; methods to better handle catastrophe losses; better communications with customers; and Superfund reform, to name a few.

But little mention was made of the financial health of the property/casualty industry. And, no mention was made of the need to raise rates, except in the course of the discussion on natural catastrophes.

Antitrust concerns aside, this silence strikes us as curious. To wit:

- A.M. Best Co. earlier this month reported that the property/casualty industry's combined ratio in the fourth quarter of 1993 is expected to hit 114.5%, a much poorer result than had been expected.
- Standard & Poor's Insurance Rating Services predicts that significant improvement in insurer profitability over the short to medium term is less likely now than a year ago.
- The bullish market for insurance and reinsurance company stock offerings, which reigned throughout most of 1993, has dried up. Companies are pulling offers from the market and, in some cases, are waiting for improved conditions or are examining alternative sources of financing, like debt instruments.

As all of these events are unfolding, January 1994 renewals have come and gone without any significant change in market conditions. In fact, risk managers report that they were surprised with the rates—especially for property insurance—they were quoted during renewals.

Do not get us wrong: We are all in favor of bargains for risk managers at renewal time. However, more than ever, we are concerned—darned scared may be more accurate—that huge, crippling rate hikes reminiscent of 1985 could be in store for risk managers.

Environmental claims are increasing against liability

"WHAT DO YOU WANT?"

insurers as each day passes. And, while the outlook for meaningful Superfund reform is brighter now than in the past several years, reform will not wipe away these massive liabilities.

A large part of insurer profits over the last two years has been fueled by stock market gains. Where will insurers stand if the market takes a nosedive?

And, while the industry now knows that it can withstand a $15 billion catastrophe, can it say the same about a $40 billion or $50 billion disaster?

As we've said over and over, the relationship between insurer and policyholder is based on trust. If property/casualty insurers and reinsurers do not look to the future and base their current pricing policies on what they foresee, that trust will be impaired.

However, if insurers impose huge rate hikes for whatever reason, the trust that began to erode among policyholders in the mid-1980s will disappear.

That would be a disaster that would rival any earthquake or windstorm.

Letters

PBGC should aim to reduce claims rather than deficit

To the editor: Your Dec. 27 editorial calls for the enactment of "reforms to finally put the Pension Benefit Guaranty Corp. on a sound financial basis." Like other members of the public, including the Congress, you apparently accept the following statement of Secretary of Labor Robert Reich explaining the need for a package of 20-plus legislative proposals to strengthen the PBGC:

"The financial security of thousands of Americans covered by single-employer pension plans is at risk, because their pensions are underfunded. There has been dramatic growth in underfunding. . .expected to exceed $45 billion. . .pos(ing) an unnecessary and unacceptable risk for workers and retirees. And PBGC, already facing a $2.7 billion deficit, is further jeopardized by this growing underfunding."

The $2.7 billion deficit is the most prominent figure cited by the PBGC to demonstrate the seriousness of its financial problems. The PBGC arrives at its deficit by deducting assets from liabilities (the usual way to compute deficits), but then adds in a puzzling item, "probable net claims," which represents the PBGC's estimate of claims it is likely to have to assume in the near future from plans expected to terminate because the sponsors are in dire financial straits. The probable net claims are not actual claims and increased the usual deficit by a sizable average of 81% in 1990-1992 ($1 billion out of the PBGC's $2.7 billion deficit in 1992), putting a more negative spin on the deficit than is warranted. (The PBGC does not explain why it chooses to ignore premium and investment income in determining its modified deficit.)

Another way to look at the deficit is to relate it to assets: It dropped as a percent of the assets from 75% in 1985 to 27% in 1992, a fall of nearly two-thirds. The size and trend of the deficit do not then support what the PBGC asks the public to believe, namely, that the $2.7 billion deficit indicates "a threat to the ability of the PBGC to safeguard pension benefits."

Secretary Reich also held out as a portent of long-term problems the estimate by the PBGC of $45 billion in current underfunding of all 65,000 active defined benefit plans. The PBGC implies that the underfunding of $45 billion is a shadowy menace, which it is not. There should be no stigma attached to underfunding arising from sound actuarial methods for budgeting plan costs that include a past service liability. Long-term rates also are currently at their lowest, leveraging the underfunding upward.

The agency believes that $12 billion of the $45 billion is attributable to plans of sponsors in "difficult financial circumstances," but this amount is most doubtful because judgments are required with respect to a multitude of factors that can vary widely over each year for a variety of reasons.

There are two additional indicators that the PBGC is in better financial condition than it seems willing to admit. One is the net cash flow generated by the excess of income items over disbursements: The average annual net income rose nearly 500% to more than $600 million in recent years. The other indicator is the ratio of assets to the sum of benefits and expenses: At the end of 1985 there was $5.69 for each dollar of payout, and at the end of 1992 there was $8.59 per dollar, a hefty jump of 51%.

Based on the above, I do not believe that Secretary Reich and his task force have made the case for the adoption of their proposals for raising either sponsor premiums or sponsor contributions. There is merit, however, in proposals aimed at minimizing additional large claims, which should be carefully formulated.

David Langer
David Langer Co. Inc.
New York

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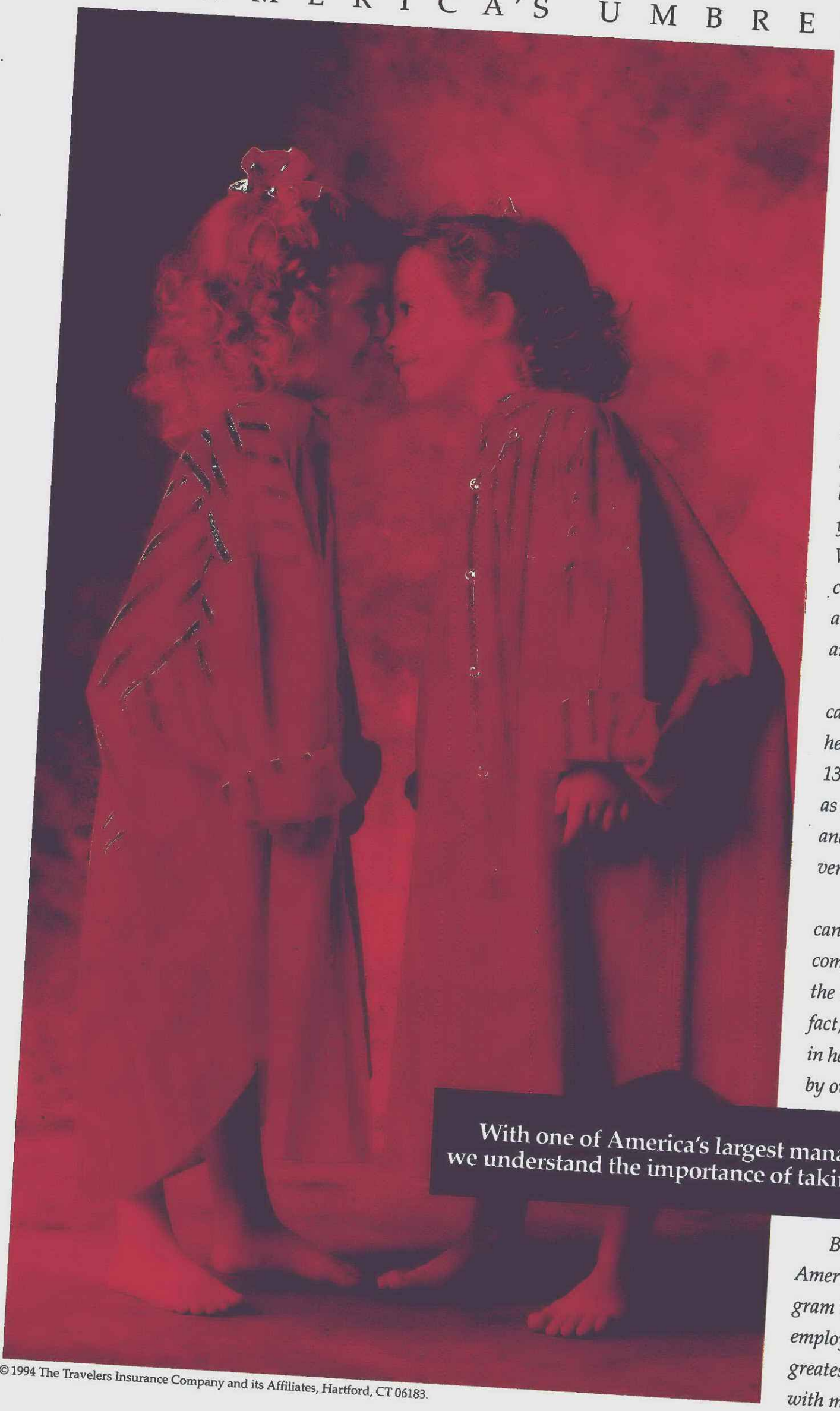

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Disasters

Continued from page 3

carefully counseled in how to deal with people who have been through the trauma of losing nearly everything they own, he said.

Continental also came out of the experience having learned new lessons, Mr. Marziano said.

For example, the cost of repairing the damage was significantly higher than the insurer had predicted, he said.

Insurers should factor in a 25% to 30% increase in normal repair costs because of shortages of material and huge demands for contractors to carry out the repairs, Mr. Marziano said.

Still, no one was fully prepared for Hurricane Andrew, pointed out Florida Insurance Commissioner Tom Gallagher.

As a result of the lack of preparation, insurers paid out more money than they need have, he contends.

"We allowed homes not to be dried-in because there was no way we had of doing it. So when the rain came, even more damage was done," Mr. Gallagher explained.

Although 7,000 claims adjusters were working in Dade County after the hurricane, they were unable to deal with the claims quickly enough to authorize waterproofing damaged homes because they were all acting independently, he said.

This also allowed homeowners to more easily file fraudulent claims because no one adjuster was familiar with a particular neighborhood. In one street, several claims were filed for the same satellite dish that had blown off one house's roof, Mr. Gallagher said.

"We only found out about it because they wouldn't let one guy use the satellite dish (to file a claim) and he told us about it," he said

To avoid these fraudulent claims and to enable adjusters to settle claims quickly, in the future adjusters from different insurers should use a common form and each adjuster should be allocated a set neighborhood, Mr. Gallagher said.

One of the best ways to reduce losses in the future is to enforce strict building codes to ensure that buildings are more likely to resist hurricane-force winds, suggested Donald L. Collins, deputy administrator of the Federal Insurance Administration in Washington.

'Tax-free catastrophe reserves are not a good idea,' asserts Ronald Bornhuetter of NAC Re.

Insisting on strict codes for buildings in flood planes has already saved the National Flood Insurance Program a lot of money and a similar approach could mean savings for private insurers with hurricane exposures, Mr. Collins said.

Enforcement of building codes is "where the rubber hits the road," agreed Jack Weber, executive director for the Natural Disaster Coalition in Washington.

"Dade County has some of the strongest building codes in the country, but because they were not enforced, the losses were 30% to 40% higher than they should have been," he said.

Despite the possibility of reducing some aspects of another hurricane loss, there is still a potential for a hurricane in Florida that could cost insurers as much as $50 billion depending on where it hits, several members of the panel said.

However, three developments have to occur together for that scenario to develop, cautioned Ronald L. Bornhuetter, chairman, president and CEO of NAC Re Corp. in Stamford, Conn.

"You have to have a storm of the right intensity, it has to hit land and it has to hit land where it will do $50 billion worth of damage," he said.

Florida authorities using that figure as a worst-case scenario are planning to set up a catastrophe fund from a levy on insurance premiums, said Commissioner Gallagher (*BI,* Nov. 15).

However, Florida is faced with a problem of having a $50 billion exposure but only $1 billion a year in property insurance premiums, he said.

"Even if you put all of the premiums into the fund, it would still take you 50 years to build it up," Mr. Gallagher said.

The reinsurance industry also does not have the capacity to finance a $50 billion loss, he said. Therefore, in the absence of a federal catastrophe fund, the state must persevere with its own fund, Mr. Gallagher said.

Insurers, state authorities, and policyholders could get some measure of relief if the Natural Disaster Protection Act were enacted, suggested Mr. Weber of the NDC.

The legislation, which was introduced in Congress last August, would give states incentives to enforce strict building codes, in addition to creating a fund that would provide financial relief to insurers following a disaster, he said.

The fund has two proposed triggers, Mr. Weber said. The first trigger would be if insured losses from a single event total 15% or more of the property/casualty insurance industry's aggregate surplus. Currently, that would mean that the loss would have to be $25 billion or more. Insurers would then call on the fund to meet claims over that amount.

The second trigger would be if an individual insurer faces losses from a catastrophe that total more than 20% of its surplus, he said.

Insurers and reinsurers should be careful not to become too dependent on the government help to meet their catastrophe losses, otherwise the insurance industry will suffer, warned Mr. Bornhuetter of NAC Re.

For example, insurers and reinsurers should not urge the government to allow companies to set up tax-free catastrophe reserves, he said.

"Tax-free catastrophe reserves are not a good idea because it would work against the insurance industry. If you follow it down the line, it would lead to even more self-insurance by firms," Mr. Bornhuetter said.

The session was moderated by Matthew Winkler, editor-in-chief of Bloomberg Business News in New York. BI

Enthoven

Continued from page 6

result in a single-payer system, which in turn would mean the end of the workers comp system within 10 to 15 years.

Fred Siskind, an economist in the U.S. Labor Department and the Clinton plan's sole defender on the panel, replied that no one has discussed federalizing workers comp. Mr. Siskind had earlier agreed with at least one thing Mr. Enthoven had said, which was that the administration needed to do "more thinking" on how workers comp would fit into health care reform.

Another Washington policymaker on the panel said that while experience rating has become a "pariah" in the health care debate, it is an absolutely essential part of workers compensation, because it encourages safer workplaces.

Shawn Coughlin, legislative assistant to Rep. Grandy, added that the Clinton proposal is currently the only reform proposal on Capitol Hill that advocates merging the two systems.

"The full merger approach will lead to increased costs," said Michael S. Pritula, a partner in the New York office of McKinsey & Co. Full merger will remove the incentives for employers to hold down costs, he said.

Deborah Steelman, a Washington attorney who served as director of domestic policy in President Bush's 1988 campaign, moderated the panel. She urged the audience to make its concerns known through calls and letters to Washington. BI

For Many Insurers, Defining The "Typical" Older American Is A Real Challenge.

Anybody who thinks the older-age market consists solely of grey-haired people in rocking chairs needs to take another look. Plenty of today's 70-year-olds prefer scuba diving to checkers. And they don't even *own* a pair of orthopedic shoes.

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Industry must control own destiny: ISO

Catastrophes, bad image not beyond control, execs say

By GAVIN SOUTER

NEW YORK—Property/casualty insurers should act to shape their own future instead of letting outside events and other people determine the success of insurers' business, two industry executives say.

For example, one executive says, insurers should act now to minimize the devastating effects of an inevitable cataclysmic catastrophe loss. And insurers should respond more strongly to misinformation disseminated about the industry, the other executive contends.

Insurance companies, and the rest of society, are much too content to wait for a disaster to happen, rather than give serious consideration to how they will cope with the consequences, warned Ramani Ayer, outgoing chairman of the Insurance Services Office Inc. during ISO's annual meeting in New York last week.

"The status quo is unacceptable. If things stay as they are, we're eventually going to get smacked with huge losses," said Mr. Ayer, who also is president and chief operating officer of ITT/Hartford Group Inc. in Hartford, Conn.

For example, an earthquake in Tokyo would lead to a melt down in worldwide financial markets and a huge loss for international insurers and reinsurers, Mr. Ayer said.

"Japan has, for years, sold off its fire and earthquake exposures to the rest of the world, London, Australia and the U.S.," he noted.

But an earthquake in Tokyo is only one potential disaster that could hit the insurance industry. U.S. insurers and reinsurers also should act in concert with state and federal governments to prepare for catastrophes in the United States, Mr. Ayer said.

Insurers should "build strong, principled underwriting programs for areas subject to windstorms or earthquakes, taking into account calculation of maximum probable loss," he said.

Also, insurers should grade the risks they cover on municipal building codes and their enforcement and provide incentives to homeowners to upgrade their structures and improve their stormworthiness, Mr. Ayer said.

Reinsurers should work more closely with insurers and more carefully assess their catastrophe exposures, he said.

"For those reinsurers choosing to write in catastrophe-prone areas, the lesson to remember from Andrew is this: spread your risks," Mr. Ayer said.

State governments ought to allow realistic rates for risks in catastrophe areas, he added.

"In coastal states, people who live with one foot on the porch and the other in the water ought to pay for that privilege. The same is true of those whose 'dream house' happens to be on an earthquake fault line," Mr. Ayer said.

Policyholders who live in safer areas should not be expected to subsidize policyholders who live in riskier areas of the country, he said.

State authorities can help alleviate the pain of disasters by establishing funds to supplement disaster reimbursements from insurers and federal funds, Mr. Ayer said.

Additionally, state authorities should ensure that their emergency response facilities are in place and ready to respond at all times, he said.

The federal government has a role to play in preparing for disasters too, Mr. Ayer said.

"The national government's role is crucial," Mr. Ayer said, predicting that the Natural Disaster Protection Act should pass soon. That measure has been sponsored in Congress by Sens. Daniel K. Inouye, D-Hawaii, and Ted Stevens, R-Alaska, and Rep. Norman Y. Mineta, D-Calif.

But physical catastrophes are not the only threats that face the insurance industry.

Misinformation about the insurers has damaged the industry in the past and insurers should act to stop it from causing further damage in the future, said Fred R. Marcon, president of ISO.

Insurers are subjected to 'virtual reality' where the truth is manipulated to fit outsiders' own views, says Fred R. Marcon. 'The public has been getting a major dose of virtual reality about the property/casualty industry from full-time insurance critics.'

Insurers are subjected to "virtual reality" where the truth is manipulated to fit outsiders' own views of the industry, he said.

"The public has been getting a major dose of virtual reality about the property/casualty industry from full-time insurance critics," Mr. Marcon said.

For example, critics of the industry have warned that several major insurers are on the brink of bankruptcy, he said.

"Those claims, of course, were nonsense and ultimately, amid great public embarrassment, the consumerist clarified the assertions. But the damage was already accomplished. Consumers' confidence in our business was needlessly shaken," Mr. Marcon said.

To help restore consumer confidence insurers should be more aggressive in finding out what consumers want and then change to meet the needs, he said.

"The successful, the long-term successful, embrace change to capitalize on their strengths and shed their vulnerabilities. That's our challenge for the future," Mr. Marcon said. BI

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AIA plans to take more aggressive role

By MARK A. HOFMANN

NEW YORK—The American Insurance Assn. must be willing to take on more risks if it is to continue its success in shaping public policy, the president of the insurance company trade group says.

"An insurance company's ability to evaluate and manage risk largely determines its success or failure. That ability determines AIA's success in the political world as well," Robert E. Vagley said at the AIA's annual meeting last week in New York.

Mr. Vagley said the AIA took the right risks last year and intends to build on 1993's successes this year.

"As a public policy organization, we succeed—or fail—based on our ability to assess the relative benefits and burdens of various issues for our membership. And we succeed based on our ability to skillfully manage our political strategies to achieve our policy objectives. In other words, we succeed based on our ability to evaluate and manage risk," he said.

Some issues are so vital to the insurance industry's financial well-being, he said, that "it is worth running almost any risk."

As an example of such a "must-win" issue, he cited reform of the Superfund law, formally known as the Comprehensive Environmental Response, Compensation and Liability Act of 1980. He pointed to reform of the workers compensation system as an example of an issue in which "the risk of inaction may prove fatal to institutions that are important to our industry and the public at large."

Despite the risks of a high-profile lobbying campaign, the AIA decided to visibly support "real change" and so launched its Superfund Improvement Project in 1993. The AIA's involvement "has provided the critical mass in building momentum for change," he said.

But Mr. Vagley warned that reform efforts remain a "high-risk proposition."

"Workers comp reform is never without risk" and often entails the threat of rate rollbacks or similar measures, he said. But by being willing to tackle the problem despite the risks, the AIA enjoyed "a year of unmatched accomplishment in advancing workers compensation reform," said Mr. Vagley.

"In the past year, we achieved significant reforms in a dozen critical states and positive law changes in eight others. We united the industry behind a common agenda that addresses system cost-drivers and mobilized the business community in our target states. Although we encountered a few bumps along the way, 1993 was a year of unmatched accomplishment in advancing workers compensation reform," he said.

A third major area of concern for the AIA and its members is the type of health care reform the Clinton administration achieves, he said.

Mr. Vagley said that when the AIA learned the administration was considering merging the medical portions of workers comp and auto insurance in a reformed health care system, "We took the risk that the best way to redirect the debate. . .was through positive and active engagement with the administration."

Those efforts succeeded, he said, but added that "much remains to be done."

Not all risks come from outside the insurance industry, he noted. For example, the AIA's efforts to reform the McCarran-Ferguson Act and to open the way for a possible federal role in monitoring insurer solvency meant "challenging industry conventions," Mr. Vagley said.

"We think a rational regulatory system should allow companies the option of an exclusive, streamlined federal regulatory track, if they so choose. There is clearly risk involved in granting the federal government any new regulatory authority over our industry. But the potential benefits—in terms of a unified, more efficient, less politicized regulatory system—are worth exploring," he said.

Mr. Vagley stopped short of endorsing a measure drafted by House Energy and Commerce Committee Chairman John D. Dingell, D-Mich., that would create a system of federal solvency regulation.

Mr. Vagley called the bill a starting point and promised that the AIA will continue to work to improve the measure. BI

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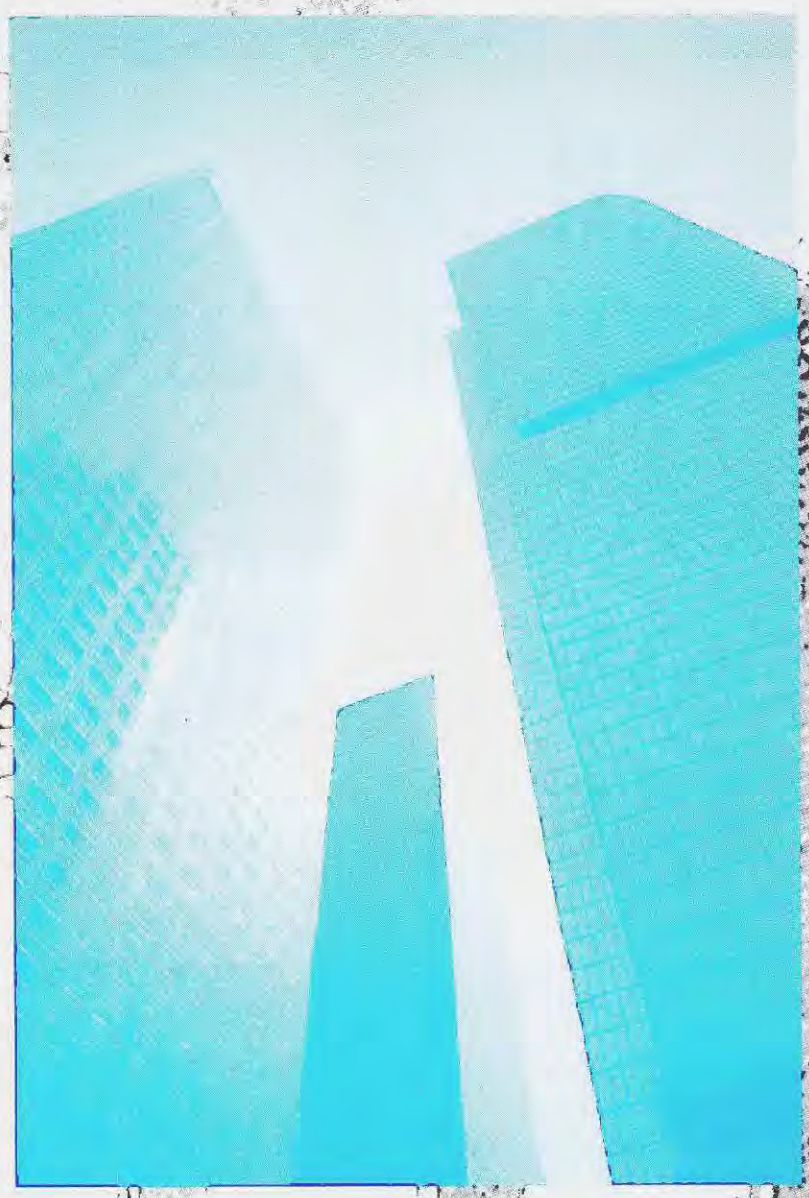

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Industry groups announce new officers

NEW YORK—The three insurance groups meeting last week at the so-called "All-Industry Meeting" have elected new officers and boards of directors for 1994.

William H. Bolinder, president and chief executive officer of Zurich-American Insurance Group, was named the new chairman of the board of directors of the Insurance Services Office Inc., during the organization's annual meeting here.

Also at ISO, Gerald A. Isom, president of CIGNA Property & Casualty Group was elected vice chairman.

At the American Insurance Assn.'s annual meeting, John P. Mascotte, chairman and CEO of Continental Corp., was elected chairman.

Douglas W. Leatherdale, chairman, president and CEO of The St. Paul Cos. Inc., was elected chairman of the AIA.

Zurich-American's Mr. Bolinder and Walter E. Farnam, chairman and CEO of General Accident Insurance Co., were elected vice chairmen of the AIA.

At the Insurance Information Institute's annual meeting, Peter Lardner, president and CEO of Bituminous Insurance Cos., was named chairman.

Also at the III, Dan D. McLean, president and CEO of SAFECO Corp.'s property/casualty operations, was elected chairman, and Kenneth J. Gorman, chairman and CEO of Atlantic Mutual Insurance Cos., was voted vice chairman.

III touts value of communications

By MARK A. HOFMANN

NEW YORK—Membership growth at the Insurance Information Institute will make it possible to cost-effectively conduct communication programs that will enhance the insurance industry's public image, according to the III's immediate past chairman.

"I believe there's a growing understanding in the industry of the value of collective communications," said D. Richard McFerson, president and enterprise chief executive officer of Columbus, Ohio-based Nationwide Insurance Cos. Mr. McFerson had served as III chairman through the group's 1994 annual meeting, which took place in New York last week.

In his address to the annual meeting, Mr. McFerson also announced that The St. Paul Cos. Inc. had newly joined the III. St. Paul's decision follows the addition of Hanover Insurance Co. last year.

The III has made expanding its membership a priority since 1991, when the organization was plagued by the loss of several large insurer members and was forced to cut its staff and refocus operations (*BI*, Nov. 4, 1991; April 1, 1991).

The III's move to expand membership and continue to build communication programs is critical, Mr. McFerson said, to counteract forces that have influenced the public's perception of the insurance industry.

Economic changes that have disrupted Western industrial democracies have also led to a dissatisfaction with public institutions, Mr. McFerson said.

"This dissatisfaction with institutions spills directly over into insurance, because the public considers the insurance industry part of the establishment and it has become a prime target for public discontent," he said. "Many see insurance as a kind of private tax: something that must be paid before they can drive their car or live in their house. To them, unfortunately, there's often little difference between an insurance company and the local tax collector."

Mr. McFerson pointed to the 1988 passage of Proposition 103 in California and the emergence of so-called "pay-at-the-pump" insurance schemes, one of which is being promoted in California and could appear on the 1996 California ballot, as manifestations of this distrust.

"We need to show people how a private, free-enterprise insurance system can help them achieve the financial security they yearn for," he said.

The insurance industry needs the III to ensure that the public is told the industry's side of any of a number of critical stories, he added.

One successful effort was the establishment of the Hurricane Insurance Information Center in suburban Miami in the wake of 1992's Hurricane Andrew (*BI*, Nov. 9, 1992). The center provided "a blueprint for future collective communications initiatives," he said.

The value of that blueprint "was vividly shown after this fall's fires in Southern California," he said.

"As in Florida, the media began looking for fast answers to their questions about insurance. The Triple I and its affiliate in California, the Western Insurance Information Service, answered hundreds of calls from print and electronic media," Mr. McFerson said. The industry's efforts even caught the attention of Cable News Network, which flashed the National Insurance Consumer Helpline's toll-free number across the screen. The help line is a joint effort of the property/casualty, life and health insurance industries.

Mr. McFerson said the property/casualty industry's understanding of the need for collective communications efforts is reflected in membership growth at the III.

"I'd like to point out as more companies join the Triple I, the more we will be able to lower membership costs. We're committed to further reductions in dues, not expansion of programs, as we continue to broaden our membership base," he said.

III President Gordon Stewart reiterated the importance of the property/casualty industry's ability to communicate effectively in the wake of natural disasters, contrasting the generally favorable image of the industry after last fall's Los Angeles fires with the very negative image it garnered after the Oakland, Calif., fires of 1991 (*BI*, Nov. 25, 1991; Oct. 28, 1991).

"Unlike what happened in Oakland, a natural disaster doesn't have to be a communications disaster for the insurance industry," he said. BI

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Employee benefit information resources

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■ A flier offered by the American Institute for Chartered Property & Casualty Underwriters/Insurance Institute of America explains a three-course program designed to help computer users **make knowledgeable choices when using automation to perform insurance-related tasks**. Request item 103.

AUTOMATED SYSTEMS AND SOFTWARE FOR INSURERS

■ A brochure supplied by Continental Software Inc. details a software system used for **group product rating, tracking and proposal printing**, as well as rate and text file updating. Request item 201.

■ RDD Corp. offers a pamphlet presenting a program that **integrates multiple managed care lines of business and multiple overlapping provider networks**, payment protocols, benefit plans and contracts. Request item 202.

■ Progressive Data Solutions offers an information packet explaining **its medical fee schedule management** system. Request item 203.

■ A **data storage** program that allows users to transfer less critical data onto cartridge-style tapes that are housed in an automated library is discussed in a booklet supplied by XL/Datacomps Inc. Request item 204.

■ A brochure from Minolta Corp. describes a system used for **scanning, indexing, retrieval, printing and faxing**. Request item 207.

■ An information packet by Resource Information Management Systems Inc. highlights systems to improve **employee benefits and managed care processing** and profitability. Request item 208.

■ The Wheatley Group Ltd. supplies a brochure detailing a system used for **policy management, premium accounting, claims management** and other features. Request item 210.

■ Genelco Inc. supplies a newsletter that covers **health care and life insurance industry trends**, legislative news and company products and services. Request item 212.

■ A brochure available from Magnus Software Corp. describes an online, real-time **flexible benefits administration system**. Request item 214.

■ A quarterly newsletter from GMIS Inc. contains information on products and services and features **how-to columns for users** of the company's automated systems and software for insurers. Request item 216.

■ A demo disk from Progressive Data Solutions lists features of a **fee schedule management system**. Request item 217.

■ An information packet offered by Resource Information Management Systems Inc. presents components of **managed care strategies and automation** for administration. Request item 218.

■ An outline of a **managed care software application** is presented on a demo disk from Progressive Data Solutions. Request item 219.

■ Pentabs, a division of Corbel & Co., provides a demo disk for automating **qualified retirement plan administration tasks,** including compliance testing, daily valuations and automatic downloading of investment data. Request item 220.

EMPLOYEE BENEFITS

■ A full-color report containing **facts and figures on the dental benefits** market is available from the Delta Dental Plans Assn. Request item 501.

■ Kelly Assisted Living Services Inc. offers a guide designed to help employees recognize if **aging parents need assistance** in caring for themselves. Request item 502.

■ A guide to **long-term disability insurance** is available from Duncanson & Holt. It includes a description of the LTD coverage and options, the underwriting process and frequently asked claims questions. Request item 503.

■ A brochure describing **utilization review and large case management** services is available from Action Healthcare Management Services. Request item 504.

■ MEDEX Assistance Corp. offers a brochure detailing **medical and travel-related assistance services** for companies whose employees engage in international travel. Request item 505.

■ A report on the status of and trends in the **managed care industry**, as well as state regulators' concerns about the managed care industry, is available from The PACE Group Inc. The report covers such topics as industry growth and consolidation, regulatory monitoring, utilization management and pharmaceutical benefits. Request item 506.

■ Options Mental Health offers an informative packet documenting how **mental health benefit programs can actually reduce employers' medical costs**. Contains selected articles and a bibliography. Request item 507.

■ William M. Mercer Inc. offers a booklet explaining how employers can **integrate the Family and Medical Leave Act** of 1993 into work-family benefit programs. Request item 508.

■ A summary of the **Financial Accounting Standards Board's proposed accounting changes for stock-based plans** and recommended corporate actions is avail-

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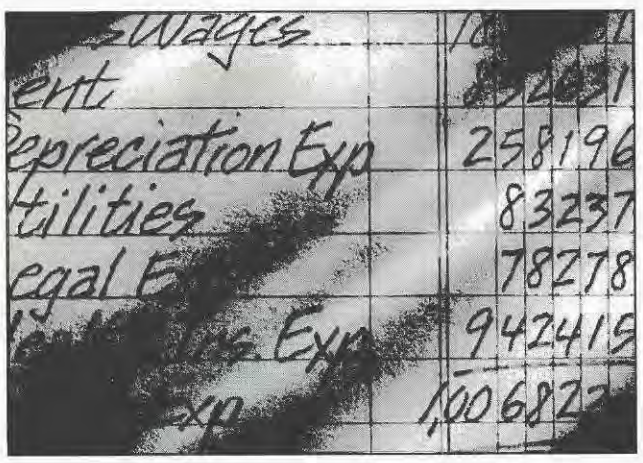

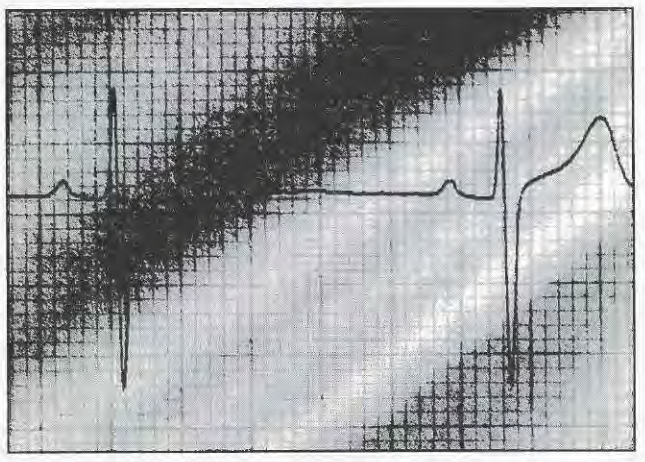

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able in a brochure from Coopers & Lybrand-Human Resources Advisory Group. The brochure examines the effect the standard would have on executive compensation and employee stock ownership plans, among other things. Request item 509.

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■ Sunderbruch/ENCOMPASS offers an article discussing the safety and cost considerations of a **vaginal birth after a caesarean section**, rather than automatically opting for another C-section. Request item 511.

■ A directory of **dental health maintenance organizations nationwide**, with information on sales, service area and licensing authority, is available from the National Assn. of Prepaid Dental Plans. Request item 512.

■ A brochure offered by The Equitable/Rotter Agency describes the **advantages of using a benefit specialist** to assist small businesses in retirement planning. Request item 513.

■ The American Compensation Assn. provides a **catalog of 1994 compensation and benefits certification seminars** nationwide. Request item 514.

■ The International Foundation of Employee Benefit Plans publishes a catalog containing information and forms for **enrolling in the Certified Employee Benefit Specialist** (CEBS) program. Request item 515.

■ An **overview of dependent care benefits** describing the types of services and programs available to employers is offered by Child Care Insights Inc./Elder Care Insights. Request item 516.

■ Dental Network of America offers a brochure describing various **dental benefit products**. Request item 517.

■ Applied Benefits Research Inc. offers employers a **free COBRA cost containment/checkup kit** to evaluate COBRA coverage operations, spot compliance problems and potential liabilities and uncover savings opportunities. Request item 518.

■ A **sample hospital cost index report** that compares a provider's specific charges with state averages for overall inpatient and outpatient services is provided by Meridian Resource Corp. Request item 519.

■ A newsletter describing a **managed care needs assessment audit** is available from CODA Inc. Request item 520.

■ BCS Insurance Co. provides a brochure explaining how employer participation in an **organ and bone marrow transplant pool** can protect its stop-loss coverage and self-insured retentions from being hit by large transplant claims. Request item 521.

■ W.F. Corroon offers Executive Signal, a periodic newsletter discussing **compensation and employee benefit issues for top executives**. Request item 522.

■ BNA Books offers its annual brochure explaining **how to calculate Social Security and Medicare benefits**, file claims and get benefit estimates. Brochures are available in both English and Spanish language versions. Request item 523.

■ A folder from Mutual of Omaha Cos. describes its group benefits operation and provides **information on various benefit categories**. Request item 524.

■ Health Ink Publishing Group provides quarterly **employee wellness newsletters and magazines** that can be customized for a particular company. Request item 525.

■ A booklet describing **health risk assessment technology** and employee wellness products is

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■ Lincoln National Life Insurance Co. offers a **needs analysis worksheet** to help employees determine proper life insurance protection. Request item 527.

■ Value Health Sciences describes its **Physician Advisor Services,** which can be used when a medical case fails to be certified through the medical review system and is then forwarded for physician review. Request item 528.

■ The National Assn. of Psychiatric Health Systems provides up-to-date information on **trends in mental health care delivery** in a 24-page, full color report. Request item 529.

■ Tips for **finding help for individuals with Alzheimer's disease** are contained in a brochure that is available from Kelly Assisted Living Services Inc. Request item 530.

■ Information on an **alternative health care program** offering cost-containment features similar to a health maintenance organization is contained in a kit available from Admar Corp. Request item 531.

■ Towers Perrin offers a survey of **post-employment benefit costs** and the impact of the Financial Accounting Standards Board's FAS 112 on employers. Request item 532.

■ FOCUS Employment newsletter, a quarterly update on new developments in **employment and labor law** and employee benefits is available from Clausen Miller Gorman Caffrey & Witous P.C. Request item 533.

■ W.F. Corroon provides Extra!, a periodic update on breaking issues affecting **employee benefits, compensation and human resources policies**. Request item 534.

■ A booklet providing a comprehensive overview of **qualified and non-qualified pension plans** and how to select the best type of plan for an employer's workforce is offered by Pension Resources. Request item 535.

■ ACP Inc. provides a sample quick reference guide that details **1994 Medicare benefits changes**. The guides can be personalized with an employer's name and logo. Request item 536.

■ A pamphlet summarizing the **rules governing fiduciaries**, trustees and plan administrators of tax-qualified retirement plans is available from The Principal Financial Group. Request item 537.

■ A bulletin analyzing the **Clinton health care plan** and offering steps employers can take now to meet anticipated changes is available from The Alexander Consulting Group Inc. Request item 538.

■ A set of nine health education handouts advising parents **how to promote healthy lifestyles to children** is offered by Northwestern National Life Insurance Co. Request item 539.

■ A brochure describing the National Foot Care Program's **flexible foot care program,** including pre-certification, provider network, claims processing and utilization review, is available. Request item 540.

■ A pamphlet on **managing pension distributions** to avoid tax withholdings when retiring or changing jobs is offered by The Equitable/Rotter Agency. Request item 541.

■ A **high-risk maternity program kit** containing worksheets to evaluate costs and materials to start a program is available from Mid-America Coalition on Health Care. Request item 542.

■ Crawford & Co. offers a 12-page brochure detailing a 10-step approach to **cost management in coordinated medical care.** Request item 543.

■ A quarterly newsletter on **Section 125 issues,** such as legislative updates, employee communication information and voluntary insurance data, is offered by Select Benefits Inc. Request item 544.

■ The advantages to employers of providing an **employee legal plan** are described in a folder and video from Hyatt Legal Plans Inc. Request item 545.

■ A brochure detailing employee benefit plan **fiduciary liability under ERISA** is available from Minet Inc. Request item 546.

■ An examination of an IRS-approved method of using casualty insurance policies to guarantee tax-deferred **executive non-qualified benefits** is available from Buck Consultants Inc. Request item 547.

■ CIGNA Group Insurance offers two brochures describing **LTD income insurance and disability management** products. Request item 548.

■ The mechanics and advantages of **self-funding group health employee benefit plans** are presented in a brochure from Medical Benefit Administrators. Request item 549.

■ A quarterly newsletter designed to help employers **educate employees about 401(k) participation** is provided by Retirement Advisors Inc. Request item 550.

■ A buyers checklist for corporate disability coverage providing guidelines for "seamless" **disability benefits** is available from Dis-

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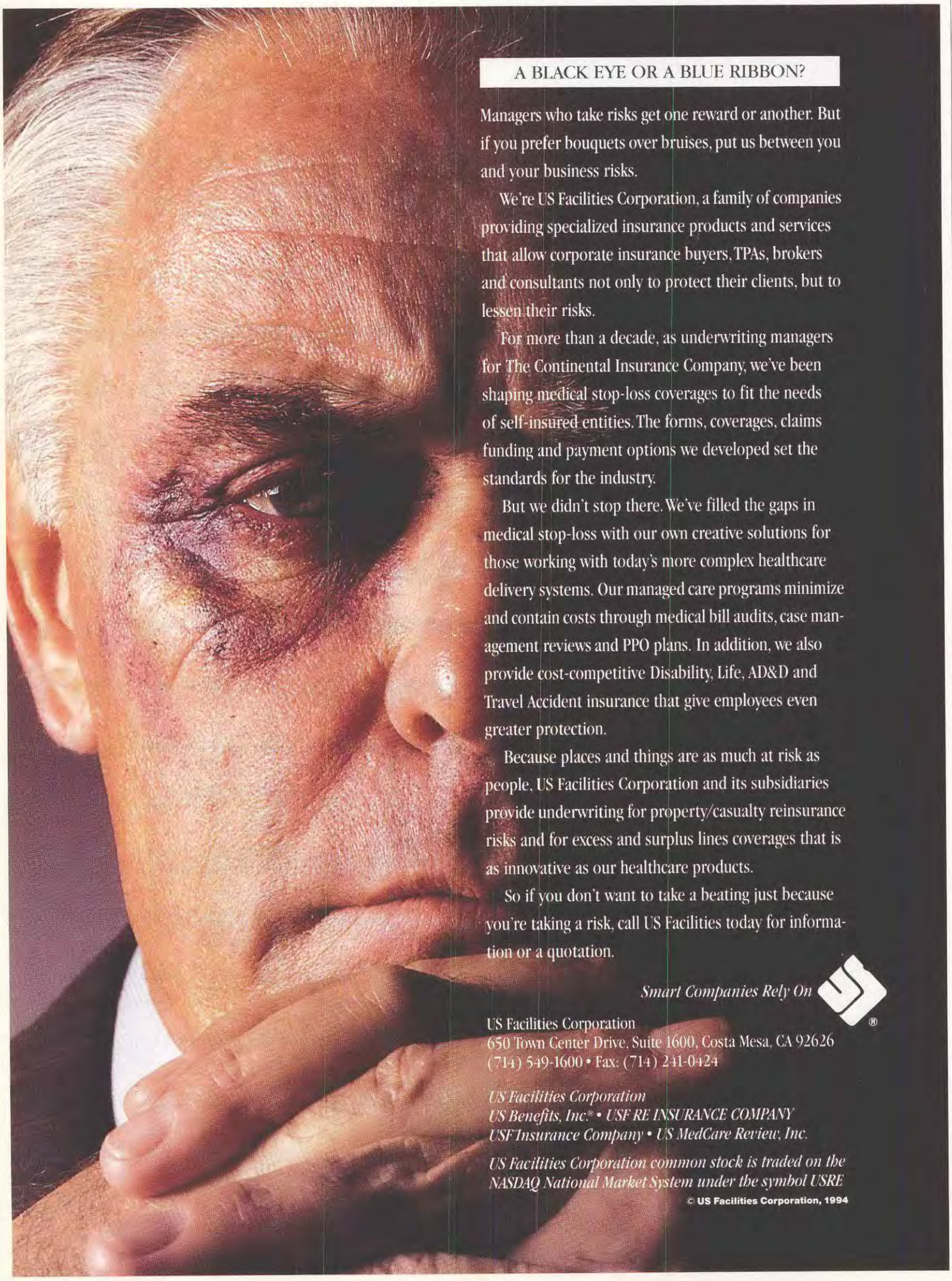

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ability Services Group. Request item 551.

■ A brochure introducing **direct reimbursement for dental benefits** as a cost-saving strategy for employers is offered by the California Dental Assn. Request item 552.

■ W.F. Corroon provides a report that gives guidance on **appropriate pension plan corrections** under the Internal Revenue Service's extension of its voluntary compliance resolution program. Request item 553.

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■ Value Health Sciences describes its role in recent and current **research projects to help improve quality of care** in a cost efficient manner. Request item 556.

■ A pamphlet containing a glossary of commonly used **terms in the health care industry** is offered by Kelly Assisted Living Services. Request item 557.

■ The American Compensation Assn. provides a catalog of **compensation and benefits** publications and audio tapes. Request item 558.

■ A brochure from Dental Network of America provides information on value-added products designed to aid beneficiaries of **Medicare supplement policies** with discounts on dental, vision, hearing and prescription drug services. Request item 559.

■An article reprint examining how medical review systems can **eliminate unneeded medical costs** is available from Value Health Sciences. Request item 560.

■ BNA Books offers a **COBRA fact sheet for employers** that explains eligibility, options and deadlines for electing COBRA benefits. Request item 561.

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■ Tips on medical benefit **rate negotiation dos and don'ts** for employers are discussed in a brochure from CODA Inc. Request item 563.

■ Mutual of Omaha Cos. offers a brochure describing its **employee benefit products and services** available to group clients. Request item 564.

■ A brochure from Lincoln National Life Insurance Co. provides assistance in **calculating retirement needs**. Request item 565.

■ The results of a survey to find the key elements of **customer satisfaction with outpatient pharmacy services** is summarized in a brochure from ValueRx Pharmacy Program. Request item 566.

■ A summary of an employer's obligations under the **Family and Medical Leave Act** of 1993 is provided by W.F. Corroon. Request item 567.

■ Ways to solve local government budget problems and **control public sector risk through cost effective employee benefit plans** are discussed in a booklet from Towers Perrin. Request item 568.

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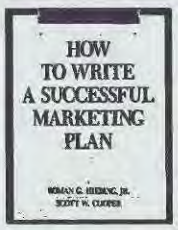

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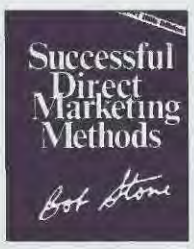

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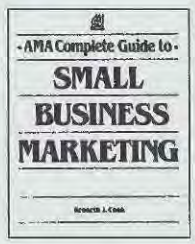

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■ A pamphlet from Kelly Assisted Living Services provides information on **organizing personal records and legal information** before an elder care crisis arises. Request item 577.

■ The Equitable/Rotter Agency offers a brochure on important principles for **investing pension plan distributions.** Request item 578.

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■ A Wall Street Journal article reprint describing the key elements of a system to **reduce unnecessary medical care** is offered by Value Health Sciences. Request item 580.

■ **Balancing risk and reward potential** in retirement planning is the focus of a brochure from Lincoln National Life Insurance Co. Request item 581.

■ A description of **managed care as a change in focus** is given in an article from Sunderbruch/ENCOMPASS. Request item 582.

■ Provisions of the Omnibus Budget Reconciliation Act of 1993 requiring employers to **broaden medical plan coverage** are discussed in a report from W.F. Corroon. Request item 583.

■ A survey of **government officials on employee health benefit costs,** risk management and cost containment is available from Towers Perrin. Request item 584.

■ The Principal Financial Group provides a guide for **employee investment in qualified retirement plans.** Request item 585.

■ A monograph exploring flexibility in **compensation and benefit strategies** and arrangements is available from The Alexander Consulting Group Inc. Request item 586.

■ Twenty short articles detailing employees' **most commonly asked questions about benefits** are available in a colorful brochure from Northwestern National Life Insurance. Request item 587.

■ The Mid-America Coalition on Health Care provides an article on reaching **high-risk, high-cost employees** with preventive health care programs. Request item 588.

■ A statistical quality control approach for **selecting and monitoring institutional investment managers** for pension investments is described in a paper from Buck Consultants Inc. Request item 589.

■ The **claims process for long-term care insurance** is the focus of a manual from Duncanson & Holt Group. Request item 590.

■ Helpful hints on **making the home safer and more comfortable** for elderly adults are contained in a pamphlet from Kelly Assisted Living Services. Request item 591.

■ BNA Books offers a brochure for employees explaining how **flexible spending accounts** work, how to file claims and the tax savings available under the programs. Request item 592.

■ **Age-weighted profit-sharing plans** are the topic of a brochure from Lincoln National Life Insur-

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InsurerTopics

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Insurers strive to clean sullied images

MetLife and Prudential dogged by association with shady sales ploys

By SALLY ROBERTS and GAVIN SOUTER

Consumer & Customer RELATIONS

Questionable selling practices have taught some customers that getting MetLife doesn't necessarily pay and that they might want to give careful consideration before getting a piece of the Rock.

New York's Metropolitan Life Insurance Co. has been on the hot seat since some agents were caught misleading customers in the sale of investment products last year. And Roseland, N.J.-based Prudential Insurance Co. has come under scrutiny because its securities brokerage unit invested clients' money in risky ventures without their consent.

MetLife and Prudential, which have built their reputations on trust and reliability, are now engulfed in a public relations quagmire as they try to salvage the confidence of existing and potential clients.

Both insurers claim that they have coped with the problems by being open and honest with customers and that this has helped to bolster their reputations. Both insurers also compensated the clients involved.

However, customers directly affected by these problems were not the only ones to notice what had happened at the two insurers. Several corporate benefit managers and risk managers say they will be more careful in their dealings with MetLife and Prudential as a result of the revelations.

MetLife's problems arose in its Tampa, Fla., office in the early 1980s, when agents started using sales practices and sales literature that described an investment product but did not always identify it as what it really was—a life insurance policy, said Charles Sahner, manager of public relations at MetLife.

While a whole life insurance policy is an appropriate product to supplement retirement income, "It is (standard procedure) at Met that the product needs to be properly identified," Mr. Sahner said. It also is standard procedure to have the literature approved by the insurer's New York headquarters. A MetLife investigation discovered that most of the literature was used without company approval, he said.

Life insurance policies differ from investment products like annuities in many ways. For agents, one of the most notable differences is in the commissions made during the first year—life insurance policies are much more lucrative.

When MetLife became aware of the sales activity, it gave refunds to 3,000 of the 18,000 customers who had purchased whole life policies from the Tampa office since 1990. The refunds were based on the cash surrender values of their policies.

The remaining 15,000 customers in as many as 37 states were informed that if they did not understand they bought a life insurance policy rather than an investment product, they could get a refund or have their money invested in an annuity. More than 60% of the 15,000 clients decided to keep the product they had purchased, Mr. Sahner said.

So far, MetLife has paid out about $11 million in refunds. The insurer is currently investigating sales activity in 14 other states, he said, noting that other offices may have used similar literature.

Earlier this month, the insurer agreed to pay a $250,000 fine to the Georgia Insurance Department "to resolve differences without any mention of allegations of wrongdoing" in its dealings with 311 customers in the state, Mr. Sahner said. MetLife also made restitution to the 311 customers affected by the sales activity, he said.

"We're not perfect," Mr. Sahner conceded. However, he added, "customers will see, regardless of the facts. . .that (they) are seen as the No. 1 priority" at MetLife. For instance, before an investigation was initiated by the Florida Insurance Department, the insurer already had offered refunds to all affected customers.

In addition, larger group health and pension customers, which were not affected by these sales tactics, can "clearly see with the numbers that we remain one of the strongest insurers financially and, if anything, we're getting stronger," Mr. Sahner said.

MetLife currently intends to develop a plan that would provide restitution to "any policyholder misled or deceived into purchasing a whole life insurance policy through inappropriate sales literature or practices," he said.

The insurer estimates that as many as 45,000 customers could have been misled into buying a life product, which could ultimately amount to $30 million in restitution.

The $30 million is small change compared with the approximately $8 billion the insurer has in capital, he noted.

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In addition to offering refunds, seven MetLife employees were either terminated, opted for retirement or their positions were eliminated. The insurer established new departments to ensure the company's rules are followed, as well as to improve sales practices for its representatives.

The new departments, which are currently in development, include a business standards committee, a "unified" customer relations department and a corporate ethics and compliance committee, Mr. Sahner said. The latter department's role is to "monitor and implement strategies ensuring business operations are fair and in full compliance with corporate policies."

"We want to make sure something like this doesn't happen again in the future," he said.

While its reputation may have been tarnished, and the incident has prompted questions from some customers, MetLife says it has not impacted sales of personal insurance policies.

Reports of questionable practices also rocked Prudential Insurance Co. last year.

The biggest surrounded the insurer's Roseland, N.J.-based securities unit, Prudential Securities Inc., where brokers allegedly violated securities laws by investing clients' funds in risky limited partnerships without consulting those customers.

In October 1993, Prudential agreed to set up a $371 million fund to pay any compensation claims.

It also came to light in 1993 that Prudential Insurance agents were improperly selling investments in a joint marketing agreement with Prudential Securities. The agents were not licensed to sell the investments, and therefore they were not entitled to split the commissions with the brokerage unit.

"It was brought to our attention in Oregon, and as soon as it was brought to our attention, we halted it," said Joseph Vecchione, vp-public relations at Prudential Insurance.

The insurer has tried to be open and honest when it is asked about the incidents, he said.

"What we do is we answer any questions and be as cooperative as possible," Mr. Vecchione said.

Prudential has also been able to rely on its reputation as an old, established and reputable insurance company, he said.

"We have an excellent reputation that has been built up over many years, and the reputation is coming into play now," Mr. Vecchione said.

The two incidents have not affected the insurer's profits, he said.

"Our figures for 1993 will show that it has been our best year ever," Mr. Vecchione said.

Meanwhile, corporate risk and benefit managers see the two insurers' attempts to restore customer confidence as appropriate.

MetLife and Prudential are "reacting reasonably well. I don't give them real high marks, but I can give them OK marks," said Gregg Conroy, manager-corporate benefits at ALCOA Fujikura Ltd. in Brentwood, Tenn.

"It takes a lifetime to build confidence, and 30 seconds to lose it," said Don MacMeekin, corporate risk manager of Dallas-based movie theater chain Cinemark USA Inc. "The restitution won't fill the jug of confidence. It eases the pain, but it certainly doesn't make me feel more confident," he said, referring to both insurers' refunds.

The insurers "need to show that they fixed what's broken and are ready to go on," he said. "Met did what was appropriate," by organizing new units and letting go of the people involved, but it could take many years to restore the confidence level to where it was.

While Cinemark does not place its insurance with Met or Prudential, their sales activities have "heightened my awareness of all the insurers I deal with," Mr. MacMeekin said.

Other benefit and risk managers agree that the incidents have made them more cautious but say the incidents won't inhibit them from future dealings with the insurers.

"It will not prevent me from doing business with them," said Mr. Conroy. However, "it is going to (raise the) question whether the business I want to do might be impacted or related some way" to their deceptive business activities, he said, adding that it will result in more in-depth questioning and investigation.

"For example, if I was looking at the Prudential in the area of pension fund investment, I would want to make more inquiries in the future about their relationship with the securities operation," Mr. Conroy said.

MetLife and Prudential's problems are "isolated incidents" and ones that could occur in very large organizations, contends Hugh Becker, director of human resources for Robbins & Myers Inc. in Dayton, Ohio. The incidents do not reflect the overall policy of the company, but rather reflect some "over-aggressive individuals" down in the company, he said. The decision to keep the insurers on Robbins & Myers' bid list is driven by the relationship, past experience and performance in that specific line of business, he explained.

The revelations should come as no surprise to people who are used to dealing with aggressive insurance salesmen, said John Veale, director of risk management at Shriners Hospital for Crippled Children in Tampa, Fla.

"It shows that the buyer needs to be as wary as always," he said.

Insurance salesmen are frequently over-aggressive in promoting their products and this problem cannot always be alleviated by seeking several quotes, Mr. Veale said.

"You can try and get competitive bids, but they are all in the same boat and they all sell in a similar way," he said.

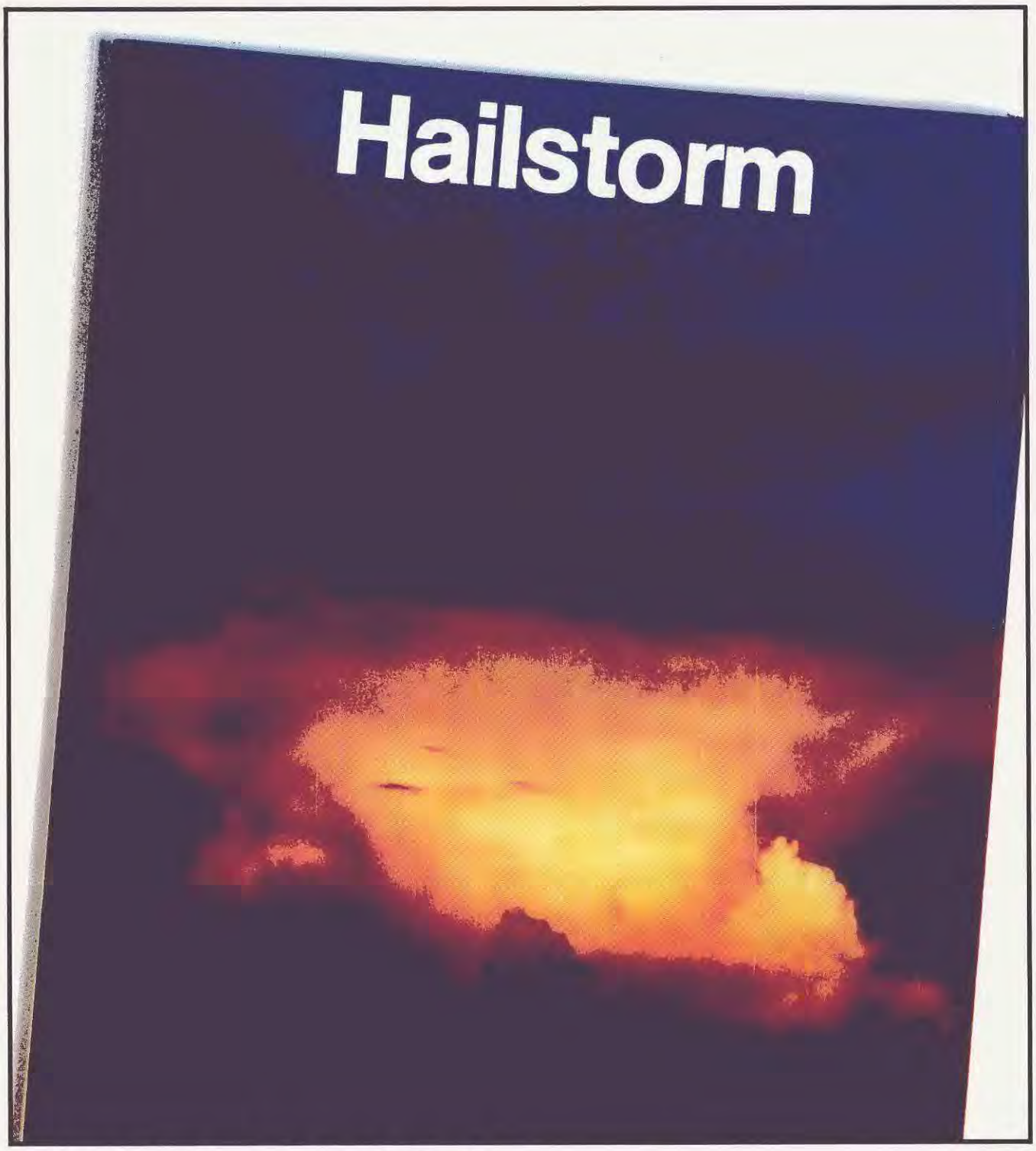
In theory, the incidents might make customers more wary of dealing with MetLife and Prudential, Mr. Veale said. "But I'm so wary of insurance salesmen anyway that it would be difficult for me to become more so," he said.

The problems can be attributed to over-aggressive marketing that frequently occurs in the financial services industry, agreed James Metz, employee benefits coordinator at Broward Community College in Fort Lauderdale, Fla.

"What happened has had no affect on me at all," he said.

Broward uses Prudential to insure its dental program, Mr. Metz said.

"(The incident) does not change my view of our arrangements because the Prudential has reserves for each part of the company, and I'm very happy with the people I deal with there," he said. BI



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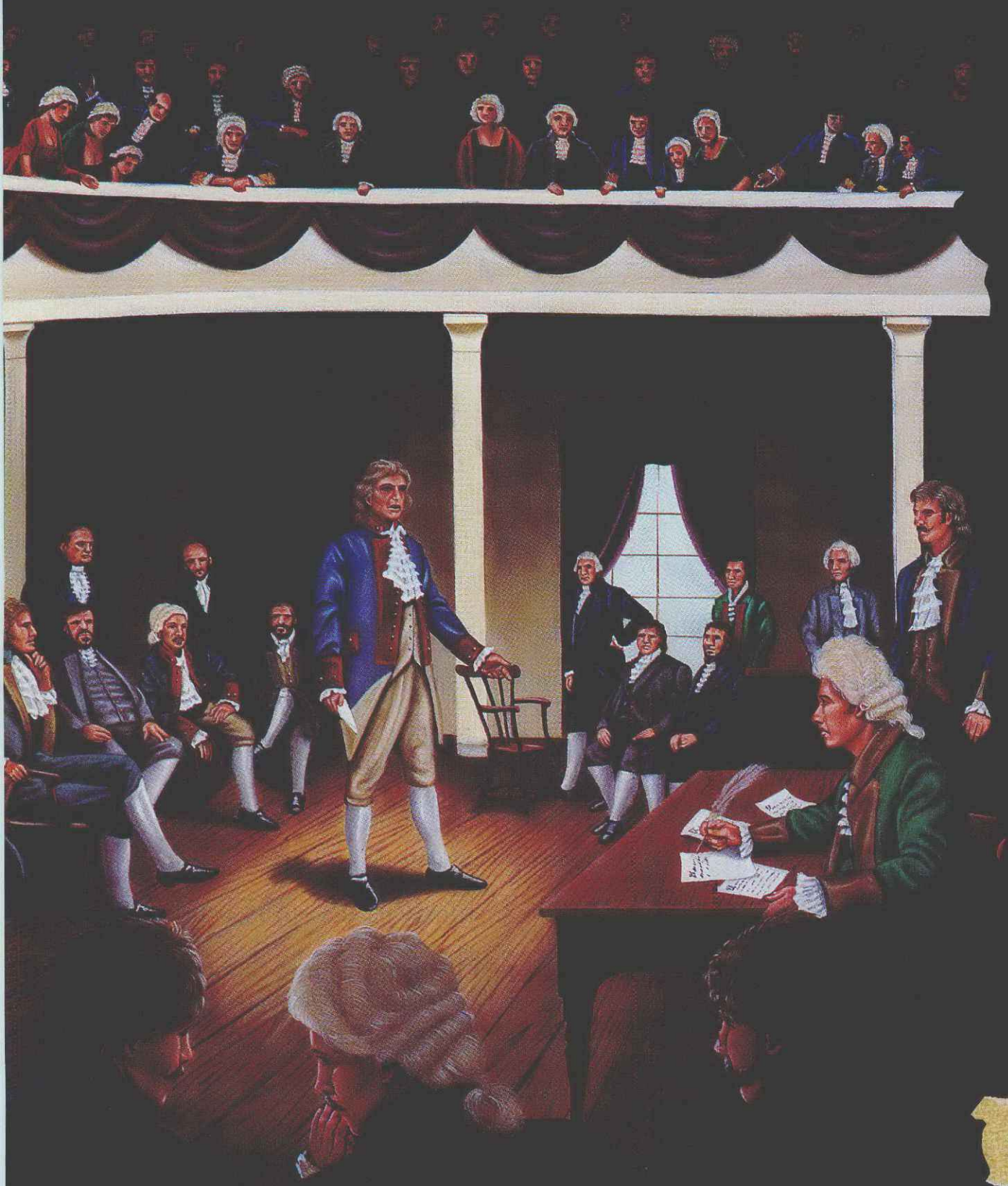

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Insurer Topics

Consumer reactions to fraud

Claims padding less acceptable: Study

By MARK A. HOFMANN

Nearly one out of five people deem it acceptable to increase the amount of an insurance claim to recoup premiums paid when they had no claims, a new survey shows.

And 22% of the people surveyed regard claims padding as an acceptable way to make up for the deductible they would be required to pay, according to the Insurance Research Council's "Public Attitude Monitor 1993."

The survey by the Oak Brook, Ill.-based public policy research organization also found that most people think that there are too many personal injury lawsuits filed and that the awards and settlements for personal injury lawsuits are too high.

However, more than three out of four of the people surveyed said they would hire an attorney if they were seriously injured in an accident and nearly half said they'd turn to a lawyer if they suffered any injury.

The survey also found that the majority of employees surveyed believe they work in a safe workplace. In addition, among those who reported hazardous conditions at work, most said that their employers were taking steps to mitigate them.

The percentage of respondents willing to accept a certain amount of fraud in the form of claims padding represents a significant drop from previous IRC surveys.

For example, 31% of the respondents to the 1989 survey agreed that padding a claim to recoup the deductible was acceptable and 25% of the respondents to the same survey said that increasing a claim to make up past premiums was all right.

The survey found a definite geographic disparity among respondents who said that padding claims was acceptable under certain circumstances. Respondents from the Middle Atlantic states—New Jersey, New York and Pennsylvania—were the most likely to approve of increasing claims to make up the deductible, with 39% saying that they agreed or probably agreed with the practice.

Mid-Atlantic state residents were also the most likely to approve of padding a claim to recoup past premiums, with 41% deeming the practice acceptable to a certain degree.

In contrast, citizens of the West South Central states—Arkansas, Louisiana, Oklahoma, Texas—were the least likely to approve of claims padding. Only 10% of the respondents of that region said that it is acceptable to increase a claim to make up for the deductible, and only 9% found padding claims to make up for past premiums acceptable.

When asked about the degree of litigiousness in American society, 70% of the respondents said that the number of personal injury lawsuits is too high. Fifteen percent of the respondents said that the number is "about right" and 13% said they didn't know. Only 2% said that there are not enough personal injury lawsuits.

On a related question, 58% of the respondents said that the awards and settlements in personal injury lawsuits are too large. Another 19% said that the size of awards are about right, and 17% said they didn't know. Six percent judged the awards were too small.

But despite the majority of respondents' reservations about the number of personal injury lawsuits and the size of the awards, respondents showed little reluctance about hiring a lawyer if they have an injury claim.

For example, 79% of the respondents said they'd hire an attorney if they filed a claim with their own insurance company after being "seriously injured" in an auto accident. Eighty-one percent said they'd take the same action under the same circumstances if they filed a claim with another auto insurer.

And nearly half of the respondents—47%—agreed with the statement: "I would always hire an attorney when injured in an auto accident" if they were filing a claim with their own insurer; 49% agreed with the statement if the claim was filed with another party's insurer.

Forty percent would turn to an attorney if they had suffered no injuries but their vehicle sustained "substantial" damage if filing a claim with their own insurer; 42% said they'd do the same if the claim was being filed with another insurer.

The IRC survey also found that employed respondents presented a generally favorable picture of safety in the workplace, with 62% of the respondents reported no serious safety hazards where they worked, while 37% said that serious hazards did exist in the workplaces. The remaining 1% did not know.

Eighty-four percent of those who reported serious workplace hazards said they thought their employer had "taken appropriate steps to reduce the risk of injury" while 15% said that their employer had not. Once again, 1% did not know.

More than two out of three—68%—of all employed respondents said their employer had talked about safety or provided safety training or instructions. Twenty-seven percent said they had received no such information and 5% did not know.

Eighty-two percent of the employed respondents judged their employers to be "strongly committed" or "somewhat committed" to safety. Six percent considered their employers to be "not too committed" to safety and 2% said that their employers were "not at all committed" to safety. Nine percent did not know.

Roper Starch Worldwide Inc. conducted the survey for the insurance industry-supported IRC. Roper Starch interviewed 2,004 people over the age of 18 for the survey, which was conducted from May 15-22, 1993.

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Single copies of "Public Attitude Monitor 1993" cost $10 and are available form the Insurance Research Council, 1200 Harger Road, Suite 310, Oak Brook, Ill. 60521; 708-572-1177.

Enhance rebuts Moody's report

By JUDY GREENWALD

A rating agency's prediction that financial guarantee reinsurer Enhance Financial Services Group may face significant losses in its commercial real estate portfolio is being disputed by Enhance as well as other rating agencies.

In a Dec. 20 report, Moody's Investors Service Inc. said there is "significant potential for additional losses" in Enhance's real estate portfolio. While its claims-paying resources are "sufficient at this time," the report says, if there are significant future losses, New York-based Enhance Financial Group will have to infuse capital to protect its Aa3 debt rating as well as the Aaa claims-paying ability rating of its New York-based operating subsidiary, Enhance Reinsurance Co.

Of the 18 real estate transactions in Enhance's portfolio, 14 "are deemed by Moody's to be of speculative grade quality," the report says. All 14 transactions were assumed from New York-based financial guarantee insurer Financial Security Assurance Inc., which has had losses stemming from three defaulted commercial mortgage transactions.

Three other transactions are also in default, though they are still making all scheduled debt service payments, according to the report.

The report states that "the magnitude of the loss potential cannot be determined at this time, and in part depends on the outcome of ongoing negotiations between FSA and the parties involved in the transactions."

FSA, which postponed a planned initial public offering last month pending improved stock market conditions, has been restructured to reduce its exposure to commercial real estate transactions. The bulk of its portfolio is now reinsured with a separate company owned by two shareholders (*BI*, Nov. 22, 1993). This does not affect Enhance's exposure, however.

Richard Wolfe, a Moody's analyst who co-authored the Enhance report, said, "We're focusing on worst-case scenarios, and our conclusions are based on the impact on Enhance of the worst thing happening in the near term. We have to focus on that because this is a financial guarantee rating. Everything focuses on it remaining Aaa."

Wallace O. Sellers, Enhance's chairman and chief executive officer, said, however, "We feel the concerns are not appropriate."

While it is "obvious" that Moody's rating would be re-evaluated if there were additional losses, "I do not anticipate any additional significant losses."

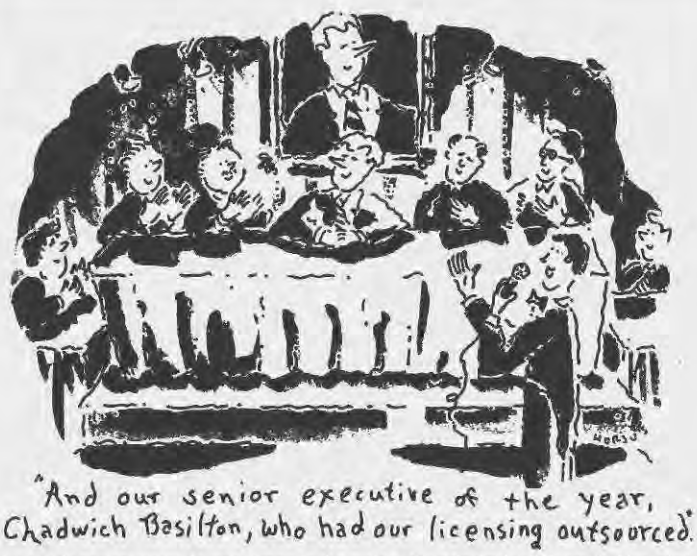
Other rating agencies agree.

"We think that the portfolio has, if anything, improved over the last year," said Donald H. Pasten, vp at Duff & Phelps Credit Rating Co., which rates Enhance Reinsurance Co. as well as its second operating subsidiary, Asset Guaranty Reinsurance Co., AAA.

"We're comfortable that Enhance is in good shape, and there's no cause for the crisis that the Moody's article seems to imply," he added.

Richard P. Smith, senior vp at credit rating agency Standard & Poor's Insurance Rating Services in New York, which rates Enhance Re AAA and Asset Guaranty AA, said, "We believe that Enhance is very well capitalized as measured by margin of safety," which is defined as the amount of capital that would be left over after claims are paid in the event of a worst-case Depression scenario.

"Enhance has one of the stronger numbers in the industry," said Mr. Smith, referring to the margin of safety. "There's no concern as it would relate to Enhance." BI



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Report eyes life insurer risks of investing in derivatives

By MARK A. HOFMANN

Life insurers with investment portfolios laden with so-called derivative financial instruments could face some profit problems, says a recent report by Moody's Investors Service Inc.

The analysis came in a December 1993 special comment by the rating company titled "Credit Implications for Life Insurance Companies that Invest in Derivative Instruments."

According to Moody's, derivative instruments are those that derive "their value generally from cash flows or other values associated with separate, underlying financial instruments."

The most common type of derivative instrument favored by life insurers are mortgage-backed securities like collateralized mortgage obligations.

Mortgage-backed securities provide a cash flow based on the funds generated by a pool of residential mortgages. But the cash flows are very sensitive to interest rates because holders of residential mortgages can pay off their loans ahead of schedule by, for example, refinancing at lower interest rates.

According to the analysis, insurers have turned to the new instruments to reap higher yields than provided by Treasury bonds while avoiding some of the riskier investments that insurers favored in recent years.

"The failures of Executive Life, Mutual Benefit and First Capital and the general downturn in the real estate market led to greater scrutiny of insurers with large exposures to junk bonds and commercial mortgages.

"In addition, the National Assn. of Insurance Commissioners' risk-based capital formula increases the amount of capital that must be allocated to (back) such investments, but it does not do so for (mortgage-backed securities), which are usually highly rated securities.

"As a result, insurers have acquired Aaa-rated securities at attractive spreads over Treasuries while improving their risk-based capital rates. However, the nature of (mortgage-backed securities) complicates the task of asset-liability management because the investor faces interest rate risk in a falling rate environment as well as in a rising one," the report says.

The report notes that recent surges in mortgage prepayments have made it difficult for investors to predict how some of these securities will behave.

"Moody's believes that some insurers assumed more reinvestment risk in purchasing particular forms of (collateralized mortgage obligations) than they'd bargained for" because they were prepaid much earlier than expected, according to the analysis. The report contends that life insurers with a large percentage of mortgage-backed securities in their portfolios might suffer erosion of their profit margins.

Mortgage-backed securities can be attractive for insurers that can reprice their fixed-rate liabilities at least once a year or that have floating rate liabilities, the analysis says. It warns, however, that the complexity of the securities "increases insurers' exposure to interest rate changes and makes sound asset-liability management even more essential."

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The Moody's report is not available to the public.

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Insurer Topics

Canadian banks not yet a threat to insurers

By MICHAEL SCHACHNER

When the Canadian government in 1992 removed some of the barriers to banks writing insurance, the move raised the specter of increased underwriting competition for Canadian insurers.

However, with the exception of one bank, Canada's banking industry has largely stayed out of the insurance business.

That doesn't mean insurers are completely at ease. Said a spokesman for Sun Life Assurance Co. in Toronto: "Nobody (in the insurance industry) is particularly happy about it, but for the foreseeable future banks won't be real competition. We do our lines of business much differently from how they do theirs."

The bank that insurers probably are keeping the closest eye on now is The Canadian Imperial Bank of Commerce. The bank, Canada's second-largest, is clearly running like the hare, compared with the tortoise-like pace of other large banks on the road to becoming insurance underwriters.

CIBC recently began writing accidental death and dismemberment insurance policies through one of its three wholly owned insurance subsidiaries, and the Toronto-based bank is currently reinsuring about $116 million Canadian ($87.9 million) in annual life insurance business that it markets on behalf of several insurance companies.

CIBC also bought an established Quebec-based personal lines insurance company earlier this month in an effort to strengthen its position in what could eventually become an incursion into insurance by Canadian banks.

But, while other large Canadian banks—including Royal Bank of Canada, the Bank of Montreal or Toronto Dominion Bank—take a cautiously slow pace, CIBC has no intention of slowing down and suffering the same fate as the hare in the famous fable.

Dwight Lacey, CIBC's chief executive of insurance operations, said the bank's insurance units will begin writing more standard forms of life insurance within the next few months and hopes to underwrite a range of individual and group products over the next couple of years.

And, by the time the Canadian government reconsiders banking laws in 1997, CIBC is planning to be a multifaceted financial services company capable of selling all forms of insurance from its branch offices, Mr. Lacey said.

CIBC's goal by 1998 is to write at least $500 million Canadian ($378.8 million) in multiline premiums.

That goal, however, will require much effort, because for now, Canadian banks must establish separate units to sell insurance, and those units cannot be located in any bank facilities.

Because of this restriction, banks' insurance operations are deprived of easy access to potential insurance buyers. As a result, most banks have steered clear of the insurance field, bank officials said.

In addition, Canadian law continues to forbid banks from target marketing a buyer. For example, if a bank wanted to send a piece of direct mail about auto or homeowners insurance to one of its credit card holders, the law requires the bank to send the exact piece of mail to every one of its credit card holders.

"When you can't sell insurance from your branches, and you cannot target-market your customer base, it's very difficult and very expensive to sell your products," said Bill Fearn, senior vp-insurance operations with Toronto Dominion Bank.

He said TDB would stay on the outskirts of the insurance business until these laws are dropped, possibly in 1997 when the Canadian Bank Act is reviewed.

In the meantime, TDB, like many Canadian banks and their American counterparts, is selling only "sponsored" insurance products that are actually underwritten by insurance companies. The banks may receive a commission on the business or, like CIBC, it may actually reinsure the business.

"By preventing banks from selling from their branches as well as prohibiting target marketing, regulations now eliminate the two means by which banks can successfully sell insurance," said Kevin Wright, an adviser with the Canadian Banking Assn. "Most banks are involved in insurance, but not as actual underwriters."

But Mr. Wright said insurers fought hard in 1992 when the Canadian Bank Act was last rewritten, and will likely join forces to lobby against banks when the act is revisited in 1997. "The insurance lobby against allowing banks is strong," he said. "Agents see banks as a threat to their domain and this argument will come up again."

"Banks are only in the early stages of writing insurance," said Dan Richards, president of Marketing Solutions, a Toronto-based financial services consultant. "The most a bank can really do now is lay a foundation for a better future, and that's assuming that banks can eventually sell from branch offices. If that doesn't happen, the banks' role in insurance will remain limited."

Mr. Lacey agreed that CIBC is just getting its feet wet in insurance.

"Accidental life is only an initial product that will help us convert banking customers into insurance customers. We need to know our products and perfect our operating systems and customer service before branch volume comes up. We're not totally disappointed that we still have time before branches will be allowed to sell insurance," he said.

Meanwhile, two other major banks are saying that for now, corporate policy and regulatory restrictions will keep them out of writing property/casualty insurance.

"We are very disappointed that we are not allowed to offer our customers traditional property and casualty and life products along with the best of the insurance industry," said Chris Markwell, president and CEO of RBC Insurance Holdings Inc., the insurance unit of Royal Bank of Canada. He noted that if it were not for tight marketing restrictions, Royal Bank might pursue insurance underwriting more aggressively.

And, the Bank of Montreal said insurance is simply a "strategy that we have not chosen to pursue. We can't be all things to all people," a spokeswoman said.

So, as 1994 begins, CIBC is embarking on the insurance course mostly alone.

"All the banks will eventually enter the insurance business, but at different times and in different ways," Mr. Lacey said. "We're charging ahead because we've decided that it will take a few years to establish a total financial services relationship with our customers. Regulations don't really allow us to do that now, but we can't wait until the banking regulations are changed."

And when CIBC does bring insurance products to market, "They'll be aggressively priced, but priced for profit. We're not shooting to enter the market with a cheap product that will force us to raise prices later on."

Will Canadian citizens be willing to buy insurance from their bank?

Mr. Richards of Marketing Solutions, citing a recent study performed by the company, said they might. "About 20% would consider buying auto or home insurance from their bank, and about 12% would consider buying life or health insurance from their bank. But considering it and doing it are different things." BI

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ance Co. Request item 593.

■ The roles of **managed care and quality care** in health care reform is presented in an article from Sunderbruch/ENCOMPASS. Request item 594.

■ W.F. Corroon provides a report on **the employers' role in health care reform** and interim steps employers can take while waiting for reforms to be enacted. Request item 595.

■ Reducing employers' **costs of untreated depressive illnesses** is the focus of an article available from the National Foundation for Depressive Illness. Request item 596.

■ NILS Publishing Co. supplies a newsletter containing **news and analysis of events in the health insurance industry**. Request item 597.

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■ Value Health Sciences overviews its medical review system, an interactive **utilization management system,** and its practice review system for **claims processing and claims analysis.** Request item 5600.

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■ A report discussing the impact of the Omnibus Budget Reconciliation Act of 1993 on **pension, stock bonus and profit sharing plans** is available from W.F. Corroon. Request item 5602.

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■ A sample copy of **Benefits magazine** is available from Applied Benefits Research Inc. Request item 5609.

■ Sunderbruch/ENCOMPASS provides an article discussing the use of managed care to control the cost of **maternal and infant health services.** Request item 5610.

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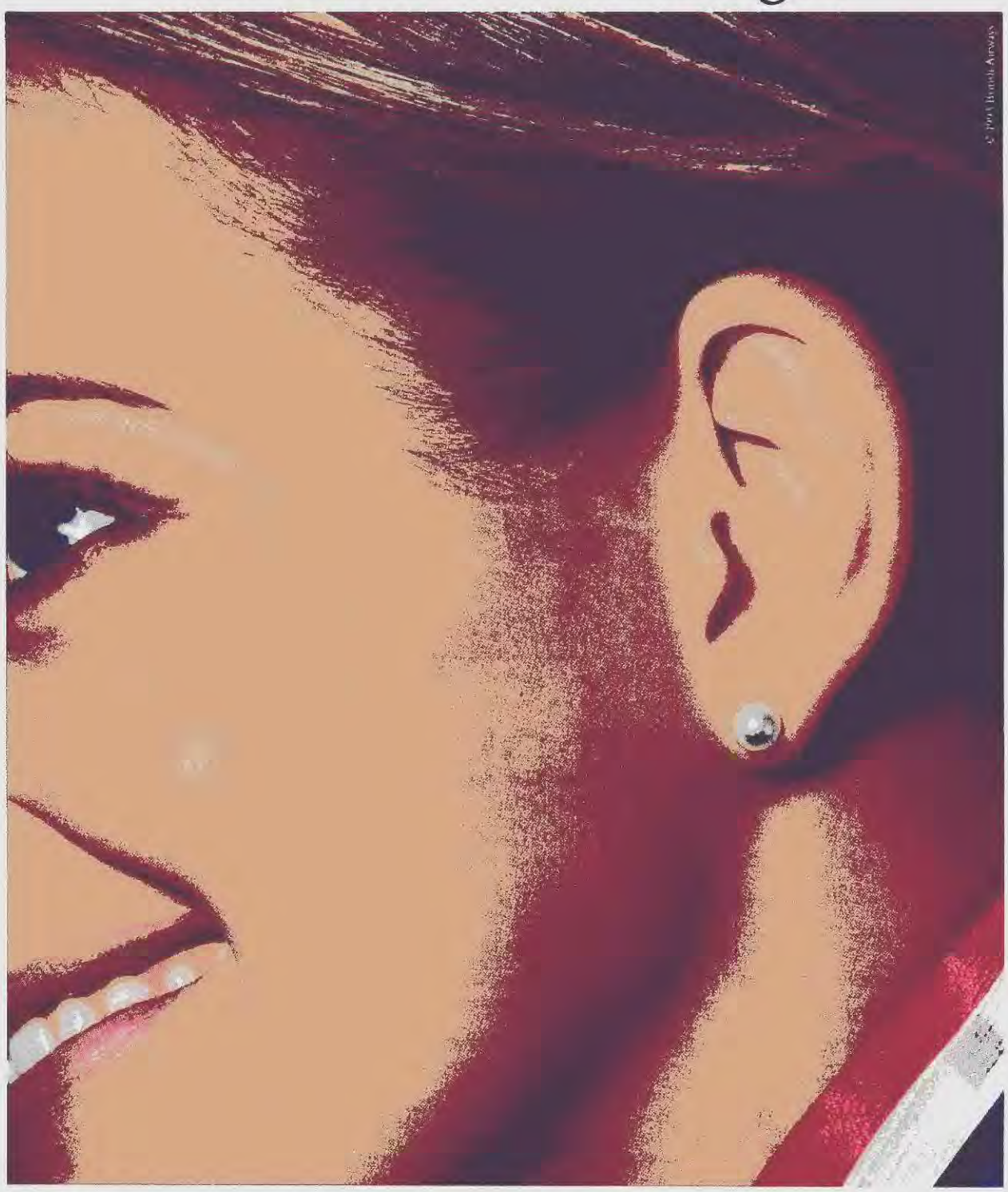

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Wrongful termination cases

Corporate policy should require use of ADR strategies

By Thomas F. Byrne

UNJUST DISMISSAL OR WRONGFUL termination claims against employers have increased dramatically across the United States during the past 10 years. Unfortunately, employers do not typically have insurance coverage for these claims.

Insurers have denied employers coverage under the typical comprehensive general liability policy because an employee's termination is considered an intentional act that is not an "occurrence" nor an "accident." Also, even if the employer's actions in discharging an employee unintentionally violated the anti-discrimination requirements of Title VII of the federal Civil Rights Act of 1964, the act of discharging the employee is still considered intentional and, therefore, excluded from the definition of "occurrence."

Finally, insurers are also able to decline coverage as well as defense of a case involving charges of post-employment defamation (e.g. advising potential new employers of the reasons for termination) on the grounds that the post-employment defamation would still be related to the employment and, therefore, within the meaning of the exclusion for intentional acts.

Because insurers routinely deny coverage as well as the defense of employers that have been sued by former employees for wrongful termination, employers must deal with the costs of defending these claims directly. These costs are usually significant, as the defense of a wrongful termination claim will likely involve significant discovery, including depositions of the former employee as well as employees involved in the alleged wrongful termination. Also, because wrongful termination litigation has become somewhat specialized, attorneys fees are above average and can easily range in the $150-$250 per hour range.

With these considerations in mind, it is advisable for employers to have in place arbitration and/or mediation provisions in their personnel policies and procedures. These conditions bind both the employer and the discharged employee to the arbitration and/or mediation process as a way of resolving any dispute arising from an employee's termination.

The defense of a wrongful termination claim will likely involve significant discovery, including depositions of the former employee as well as other employees involved.

Such methods of alternate dispute resolution not only substantially reduce the cost of resolving the wrongful termination dispute but also result in resolving the dispute much earlier than the civil litigation process.

Before discussing typical arbitration and/or mediation agreements that can be incorporated into the employer's personnel policies and practices, it is important to understand the differences between arbitration and mediation.

Although both are forms of ADR, arbitration is conducted before a neutral party who acts as a private judge. He or she may impose various levels of formality or informality in the proceedings, as agreed to by the parties.

Parties to an arbitration may elect to be represented by an attorney; however, generally there is no requirement that a party be represented by an attorney at an arbitration proceeding. The arbitrator is usually an attorney who specializes in wrongful termination litigation and is familiar with the law in that area. Therefore, the arbitrator is able to apply the law to the facts presented by both sides, whether or not they are represented by an attorney.

Mediation also involves the presentation of facts to a neutral third party. However, the mediator attempts to facilitate a settlement between the disputing parties. Mediation is entirely voluntary, and the process continues only so long as the parties agree. The mediator has no power to impose a settlement. Indeed, in certain types of mediation, the mediator expresses no opinion as to the merits of the case or a settlement value.

In contrast, the arbitrator makes an award in favor of one party or the other, thus imposing a settlement or resolution on the parties. The arbitration proceeding may be binding or non-binding, as agreed to in advance by the parties. Usually, binding arbitration is preferred in an effort to avoid being forced back into the civil litigation process, for which arbitration was originally selected as an alternative.

An employee who has signed an agreement to arbitrate or mediate any disputes arising out of employment may be precluded from bringing a civil

Continued on next page

Meditating on mediation

Don't settle for protracted disputes; mediators can provide a fast fix

By Lee Goodman

When should claims be mediated? Mediation is being accepted by a growing number of insurance and non-insurance companies as a technique that can help to settle cases and reduce loss adjustment expenses. As experience with mediation increases, the question that risk managers, insurers and adjusters are asking is changing from whether to mediate to when to mediate. A number of events can occur in the course of handling a claim that will indicate the time is right for initiating mediation.

Perhaps the strongest indication that a case is ready for mediation is if any other party to the dispute requests that mediation be used. The request need not come from a party that is your adversary in the case. It can come from a party that is to some degree aligned with your position, such as a co-defendant. By making the request, that party has shown that it is serious about pursuing settlement. This is an invitation that should rarely, if ever, be refused.

By making the request, the party is not indicating that it is ready to give up or give in. The party is indicating, however, that it is willing to consider making some concessions. In theory, a party could suggest mediation in the belief that it will be able to persuade you to accept its last offer. In practice, however, a willingness to mediate shows that the other side is ready to listen to your view of the case and that it is prepared to consider changing its position. Once any party makes such a clear statement, other parties tend to join in the spirit of negotiation, which has a high probability of resulting in a settlement.

Unfortunately, it is not unusual for one party to decline another party's request for mediation. One recent study showed that an outright refusal to mediate, once an opposing party has suggested mediation, is a major reason more cases don't settle.

Although parties may have various reasons not to accept an invitation to mediate, the most common reason seems to be the "not invented here" syndrome. Put simply, some people will not mediate a case unless they were the first to suggest mediation. Similar thinking can be found throughout the business world, so people in the risk and insurance professions should not be singled out for their egocentricity. On the other hand, if an insurer or policyholder has established a policy of not mediating unless it is the initiating party, it should look closely at that policy to be sure that it furthers some legitimate purpose.

One of the most important reasons mediation can save money is it allows settlement to take place earlier in the litigation process. Early settlements reduce the defense attorneys' fees for discovery, pleadings and motions, which are the major component of allocated loss adjustment expenses. Insurance Services Office Inc. has found, for example, that in product liability cases that settled within the first two years, the defense costs equaled 9% of indemnity payments. For cases that settled between the second and fifth year, defense costs were 33% of indemnity, and in cases that settled after the fifth year, the defense costs were 41% of the indemnity payments. At first glance, these figures suggest that mediation should always be undertaken as early in the case as possible. There is considerable merit to this view. However, a closer look is warranted.

Traditionally, attorneys resist the idea of settling early. They are trained to believe that the more information they can obtain in discovery, the better prepared they will be for trial or settlement. To a large extent, adjusters have shared this view. Adjusters, however, have been better able to evaluate the benefits of obtaining more information as compared to the cost of obtaining that information. Perhaps because they concentrate more on negotiations than trial strategy, they know that a great deal of the information that is obtained through formal discovery is only of slight value in ultimately resolving most cases.

In some cases, enough is known almost from the outset for the suit to be settled. For example, in a breach of contract dispute, you may be able to determine very quickly whether there was a valid contract, whether it was breached and the range of damage claims. Most of the discovery efforts of defense counsel in such a case may be aimed at finding ways to cloud the issues so that the plaintiff will have a more difficult time proving his or her case. Discovery along these lines is of little value if the parties are willing to discuss settlement at an early date.

Unfortunately, it is difficult for attorneys to put an end to the discovery process. Like doctors who practice defensive medicine, lawyers are motivated to pursue marginal discovery efforts rather than be judged as having inadequately prepared a case. They become perfectionist, even compulsive, about discovery. The task therefore falls on the adjuster and the risk manager to determine when sufficient information is known so that mediation can begin.

An ideal time to enter into mediated

Continued on next page

Employee contracts

Continued from previous page
action for wrongful termination. Under the law of most states, including California, written arbitration agreements are generally enforceable and are only revocable on grounds of duress or fraud.

However, state law does provide some exceptions to the enforceability of arbitration/mediation agreements. In some states, statutes preclude mandatory arbitration/mediation of certain types of disputes such as those arising from contracts covered by the Federal Arbitration Act. The common law of most states includes the doctrine of unconscionability, which may give an employee the right to avoid the application of an arbitration/mediation agreement if the terms of the agreement are found to be harsh or unjust, or if the agreement is considered an "adhesion" contract. Such contracts primarily protect the employer's interests without providing the employee a fair opportunity to protect his or her interests.

It should also be noted that the U.S. Supreme Court has held in a 1984 decision that by enacting the Federal Arbitration Act (9 U.S.C. Section 1, et seq.), "Congress declared a national policy favoring arbitration (mediation) and withdrew the power of the states to require a judicial forum for the resolution of claims which the contracting parties agreed to resolve by arbitration." (See *Southland Corp. vs. Keating* (1984) 465 U.S.1, 10-11, 104 S.Ct. 852, 79 L.Ed. 2nd 1.)

Of course, an attorney should be consulted before drafting an Employment Mediation and Arbitration Agreement for one's company. This sample Employment Mediation and Arbitration Agreement is given as an example only:

> Your employment with employer is subject to an at-will agreement and may be terminated by you or employer at any time for any reason. There is no agreement express or implied between employer and its employees for continuing or long-term employment. While supervisors, managers and officers have certain hiring authority, no employee of employer has any authority to alter the at-will employment relationship.
>
> It is understood and agreed between the parties hereto that any claim of any nature whatsoever arising out of or connected with your employment at (name of employer), including but not limited to termination, claims of age discrimination, sexual harassment or civil rights violations, and questions regarding arbitration shall be resolved through a two-step dispute resolution process. First, the parties will mediate the dispute before an agreed upon mediator followed, if necessary, by final and binding arbitration before the same or, if requested by either party, another panelist acting as arbitrator. By entering into this contract, both parties are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration and mediation to resolve their dispute.

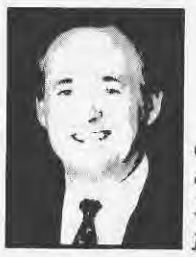
It should be noted that the parties will sign a confidentiality agreement in connection with any arbitration or mediation. Without such an agreement, the parties would be reluctant to make the kinds of concessions and admissions that pave the way for settlement of the dispute. Qualified mediators and arbitrators are able to draft such agreements, which are to be signed prior to starting the mediation or arbitration process.

To avoid the risk of incurring high civil litigation fees and costs, employers can utilize arbitration and mediation in their employment personnel policies and practices. The arbitration and mediation agreement is contractually enforceable, thus requiring that the dispute be resolved by ADR.

The benefits of ADR include not only lower costs but also accelerated resolution of disputes and preservation of amicable relations between the employer and employee. The animosity and distrust engendered by litigation can eliminate any opportunity for the parties to resume a normal relationship.

On the other hand, mediation is a cooperative process. With the help of the mediator, the parties work together to create a mutually acceptable resolution of their dispute. The mediation process can create an atmosphere that actually helps to maintain and further relationships between the parties, rather than destroy them.

Today, more than at any time in the past, employers need to reduce the costs of litigation, reach a prompt resolution of disputes with employees and protect their image in the community and the nation. Mediation and arbitration are exceptional tools in achieving these goals. BI



Thomas F. Byrne is an insurance defense attorney with Hinton, Byrne & Cochran in Santa Rosa, California. He is also a mediator for AAA Center for Mediation in San Francisco.

Mediation

Continued from previous page
settlement discussions is when the parties are awaiting a judge's ruling on an important motion, such as a motion for summary judgment. The briefs will have articulated each side's view of the case, and in preparing their briefs, each side will have exposed the strengths and weaknesses on both sides of the case. As they await a decision, each side will have a heightened awareness of the possibility of losing the case, and each side should therefore be open to reducing its risk by settling.

Instead of grasping the opportunity presented to them, however, parties will often put negotiations on hold until after the judge rules, because each side hopes to enter the negotiations with a victory in hand. They will usually find that this imbalance makes it more difficult to settle the case. The party that prevailed on the ruling will be reluctant to move off its position, and the other party will not want to negotiate from a position of weakness. The case will probably not be settled until some other event in the case creates uncertainty in the party that won the ruling.

At various points in a case, a party may uncover information that makes mediation an attractive course of action. For example, in one case, during the course of interviewing employees of a defendant, the defense attorney learned that in addition to the plaintiff's harassment complaint, five other employees were considering filing their own complaints against the defendant. If the case has proceeded toward trial, the plaintiff would inevitably have uncovered these damaging witnesses. Mediation conducted before the defense is obligated to disclose the information could bring about a more favorable conclusion to the case than would ever be possible once the information is uncovered.

Mediation may also be prompted by information being obtained by the other party.

If one side finds that damaging information has been uncovered by its opponent, it may be best to start negotiating in earnest, rather than to antagonize the opposing side by appearing to be unreasonable.

Events that are external to the particular dispute may also be an impetus to entering into mediation. For instance, a party may know that one of its employees who is an important witness is about to leave its employ. Although the witness could be subpoenaed to testify at trial, in reality, former employees are much less likely to be helpful witnesses than current employees. The employee's imminent departure may give the company a previously unforeseen reason to try to settle the dispute quickly.

You should also keep in mind that events can influence the other side to want to settle. Often, the event will not be known to you, just as your reasons for wanting to mediate will usually not be known to your opponent. It can therefore be worthwhile to occasionally suggest mediation to an opponent who has previously declined an invitation to mediate; events may have changed their mind.

In order to avoid appearing overly eager to settle, you can explain that it is your regular practice to periodically revisit the issue of mediation, even when it has been ruled out previously.

Paradoxically, the best time to mediate is often when settlement seems most unlikely. Negotiations can break down for any of a number of reasons. The personalities of the attorneys may make it difficult for them to communicate productively with one another. The parties may have become so hardened in their positions that they refuse to budge. The difference between the plaintiff's demand and the defendant's offer may be so great that neither side thinks the other is taking it seriously. If the parties follow the traditional bargaining pattern, they will in effect say to each other, "See you in court." This kind of impasse can happen at any point in a case. Some cases reach this point very quickly, and relations between the negotiating parties never improve.

The only hope for settling such a case may to be to involve a neutral mediator, who can get the parties talking to one another again. If the problem is one of friction between the attorneys, the adjuster or risk manager may be the only person in a position to recognize the problem and to break the deadlock.

As a case progresses, it may become more complicated than it started out to be. Very often, additional parties will be added. The sheer number of people involved may make direct negotiation difficult. As cross-complaints and counterclaims among the parties multiply, the complexity of the issues can confound everyone's efforts to look at the big picture and to understand each other's viewpoints. At this juncture, calling in a mediator can help to sort things out and to creatively align the parties into real interest groups that can jointly evaluate the proposals of the other factions.

Another change that can occur in a case happens when an unexpected turn of events increases the magnitude of a loss or of a party's exposure. In recent years, bankruptcies and insolvencies have had this effect. The result is that a party can find itself facing vastly greater liability than it had anticipated. Such a development can be disruptive to negotiations that had been proceeding based on presumed levels of exposure.

A similar situation arises when an injured plaintiff's medical condition takes a sudden turn for the worse or fails to improve as anticipated. The plaintiff's attorney will likely withdraw any outstanding settlement offers, and defense counsel may feel pressured. The plaintiff's anger at his misfortune may make negotiations difficult. A mediator can help the parties adjust to the situation and stay on track in their negotiations.

Because mediation sessions are confidential, there is virtually no risk in using mediation to try to settle a case early. Although most cases will settle in a single mediation, if the case does not settle, and another opportunity to settle arises later in the case, another mediation session can be scheduled. Basketball games are won by teams that take their best shots, even though some shots miss. Similarly, cases are settled by parties who try mediation when it looks like it has a chance of succeeding, and then try it again if they get the right opening.

It is not possible to foresee all the developments that may make mediation an attractive option in a case or to know when in the case the developments may arise. For this reason, it is futile to set an inflexible rule on when to use mediation. Parties who are involved in litigation or claims must be alert to opportunities for a mediator to help settle their cases. BI

Lee Goodman is the founder of Mediated Settlement Service in Northbrook, Ill.

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■ A leaflet supplied by Prudential Service Bureau describes how a **flexible benefit plan works**. Request item 602.

■ A program that facilitates **management of compensation, benefits, government compliance** is outlined in a pamphlet from Spectrum Human Resource Systems Corp. Request item 603.

■ **A COBRA administration** program is detailed in a leaflet offered by Prudential Service Bureau. Request item 604.

■ A program **for human resource data base management** is detailed in an information booklet from The Alexander Consulting Group Inc. Request item 605.

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■ A program for **human resource, payroll and benefits management** is outlined in a booklet from Spectrum Human Resource Systems Corp. Request item 609.

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■ A **retirement planning calculator card** to compute an account balance after a selected time period based on your salary and monthly contributions is available from The Equitable/Rotter Agency. Request item 801.

■ An article supplied by Comerica Bank explains the **role of captives in corporate global risk and financial management strategies** and services provided by banks to support them. Request item 802.

■ The Equitable/Rotter Agency offers a brochure on **estate planning** to help prepare for federal estate taxes that are due after the death of a business owner. Request item 803.

■ The American Institute for Chartered Property & Casualty Underwriters/Insurance Institute of America offers a flier detailing a four-course program in **insurance accounting and finance**. Request item 804.

■ A flier from The Equitable/Rotter Agency highlights the opportunities and flexibility of **investing in a mutual fund-based life insurance** plan. Request item 805.

■ An **insurer ratings list** magazine from Standard & Poor's Corp. provides claims-paying ability ratings on more than 900 companies. Request item 806.

■ Equitable/Rotter Agency offers a flier on private **pension plans funded with variable life insurance**. Request item 807.

■ An informational brochure on **tax-deferred annuities** is available from The Equitable/Rotter Agency. Request item 808.

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■ A directory of **adjusters, attorneys and claims related services** listed by state, Canadian province or country in an information booklet from Eagle International Associates. Request item 901.

■ Buck Consultants Inc. offers an article explaining how P/C database software is changing the way **multinational benefit plan sponsors** manage their worldwide pro-

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grams. Request item 905.

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■ National Health Services supplies a flier with information on **health care reform and how it may affect segments of the health care industry**. Request item 1602.

■ A 1993 directory of consultants, administrators, reinsurers, health care providers and other **firms that provide services to companies that self-insure** is supplied by the Self-Insurance Institute of America Inc. Request item 1603.

■ A guide that discusses risk evaluation, types of insurance, and other information about **underwriting stop-loss coverage for employee benefits** is provided in a 67-page booklet from Duncanson & Holt. Request item 1604.

■ WLT Software of Florida Inc. offers an information packet detailing programs on **claims and billing administration** including medical, dental, vision, drugs, disability and more. Request item 1605.

■ Corbel & Co. presents a **survey of third-party administrators**, focusing on the potential effect of national health reform on their business and trends in benefit claims administration. Request item 1607.

■ **Trends in the self-insurance medical market and stop-loss insurance** business as well as an explanation of types of coverage and the role of the third-party administrator are reviewed in a booklet from Sun Life of Canada. Request item 1608.

■ An information packet detailing a **software program for administration of self-insured health benefits**, including dental, vision and short-term disability, is offered from Associated Systems Inc. Request item 1609.

■ TXEN Inc. provides a newsletter discussing **technology to increase the productivity and competitiveness** of companies involved in the administration of healthcare plans. Request item 1610.

■ An information packet from WLT Software of Florida Inc. details a program for a **claims editing system which verifies provider billings** prior to processing, checks for incidental/elective cosmetic procedures and more. Request item 1611.

■ A brochure supplied by Helmsman Management Services Inc./ Liberty Mutual details a coordinated program of **claims, managed care, loss-control and risk management information services** as well as individual service contracts. Request item 1612.

■ Crawford & Co. provides a **directory of claims, health and rehabilitation, and risk survey offices** worldwide. Request item 1613.

■ A booklet supplied by WLT Software of Florida Inc. details flexible benefits administration software capable of **payment processing, accounting, fund tracking, check writing, proposal generation** and more. Request item 1614.

■ **Questions, answers and legislative changes** related to health care plans and third party administrators are discussed in a newsletter offered by Corbel & Co. Request item 1615.

■ An article from Self-Insurance Marketing Service outlines issues faced when **marketing products and services to self-insured buyers**. Request item 1616.

■ An information booklet supplied by TXEN Inc. details a system used for the **administration of health care plans**. Request item 1617.

■ A flier provided by SIEX explains in detail a **free "vendor locator service"** that is available to self-insurance programs. Request item 1619.

■ Value Health Sciences Inc.'s Practice Review System overview details the software's ability to analyze claims and other data to produce **practice and performance reports on networks and physicians.** Request item 1621. BI

Scholarship honors late risk manager

NEW YORK—The Thomas V. Hallett Memorial Scholarship Fund has been created at The College of Insurance to assist students studying risk management and insurance who have demonstrated academic achievement and financial need.

With proceeds of $25,000 from Mr. Hallett's estate and contributions in his memory from friends and colleagues, the fund currently exceeds $43,000.

Mr. Hallett was a senior vp with Alexander & Alexander Inc. when he died suddenly of a heart attack last March. He was 52 (*BI*, March 29, 1993). Widely respected in risk management circles, his 27-year career spanned insurance company claims work to the top risk management position at General Motors Corp. to senior positions in the insurance brokerage business.

In 1980, he was the *Business Insurance* Risk Manager of the Year.

As requested in Mr. Hallett's will, *Business Insurance* accepted contributions in his memory for the establishment of a scholarship fund. "After extensive discussions with Tom's friends and colleagues in the risk management and brokerage fields, it was decided that the most appropriate recipient of the scholarship money would be the College of Insurance," said *Business Insurance* Publisher and Editorial Director Kathryn J. McIntyre.

"The College of Insurance will grant scholarships from interest on the fund to deserving students," Ms. McIntyre said. "In addition, the College has been asked to use available funds to support forums, panels and lectures at the college that promote the development of risk management," she added.

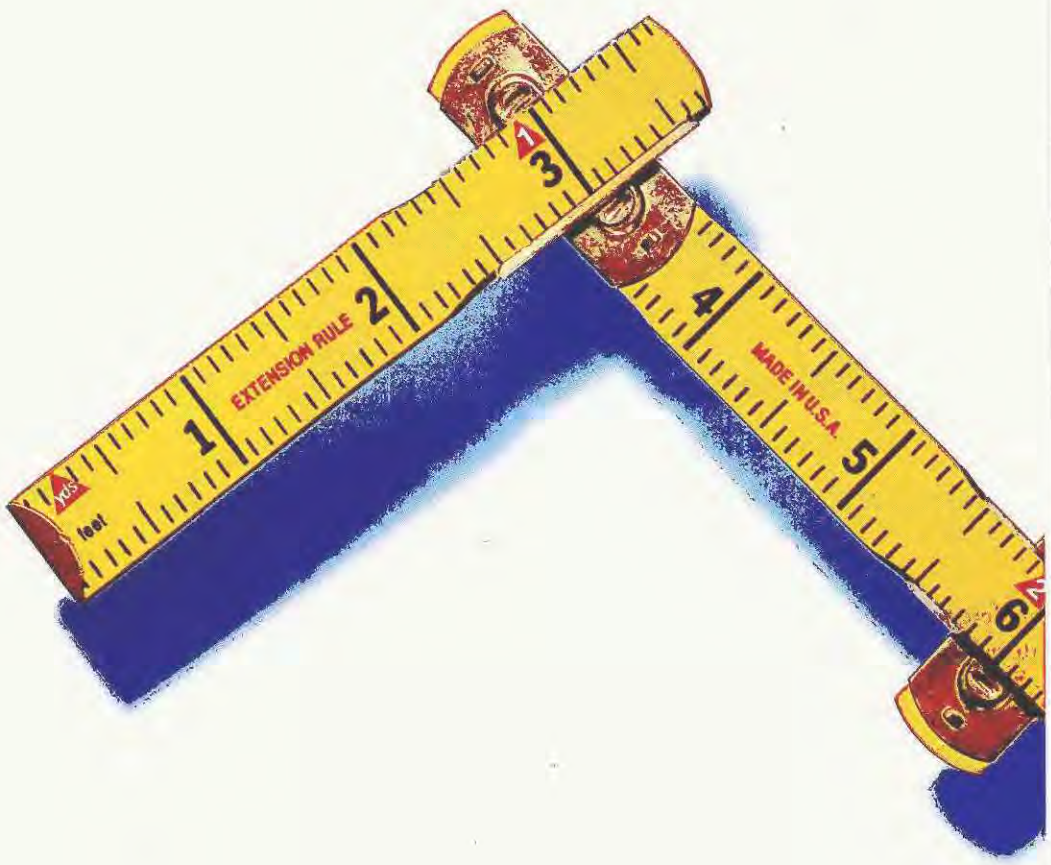
"Both the scholarships to students and the support of continuing education programs that promote risk management are fitting memorials to a man who was so committed to the continuing development of risk management as a career," said Ms. McIntyre.

Ellen Thrower, president of the College of Insurance, said, "Tom Hallett was an outstanding example of an industry leader truly committed to the advancement of insurance and risk management education.

"Tom enriched our college in many ways, serving on advisory committees, working closely with our faculty internship program and challenging and inspiring our students with his knowledge of risk management," Ms. Thrower said.

"The Thomas V. Hallett Memorial Scholarship Fund is a wonderful tribute to Tom's memory and will enable many deserving young people to attend the college and pursue meaningful careers in insurance and risk management," she said.

The Thomas V. Hallett Memorial Scholarship Fund at the College of Insurance will continue to accept tax-deductible contributions in Mr. Hallett's name. Contributions can be sent to: The College of Insurance/Thomas V. Hallett Memorial Scholarship Fund, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132. BI



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Riverboats

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these boats.

"What put us off is that we felt that the terms that were available were too competitive," he said.

In particular, the low deductibles that riverboat casino operators typically enjoy on their liability coverage are too low for many underwriters. When gaming boats were first covered in 1991, deductibles for liability coverage were commonly about $5,000, Mr. Jones said.

With liability deductibles so low, insurers have had to pay a lot of accumulated low-level losses, he said.

Over the past two years, though, riverboat casino operators have seen average deductibles rise to $10,000, and some are as high as $25,000, Mr. Jones said.

And, as larger hotel and casino chains enter the market, the level of liability coverage deductibles likely will rise even higher, he said.

"Some of these larger operators could take deductibles of $1 million if they want to," Mr. Jones said.

Several hotel chains, as well as Las Vegas-based casino operators, are looking into gambling boat ventures.

Hilton Hotels Corp. next month plans to launch one riverboat casino in New Orleans and two in Kansas City, Mo.

Hilton currently is negotiating its insurance coverage for the riverboat casinos, said W. David Little, director of risk management for the Beverly Hills, Calif.-based hotel chain. The level of its deductible will largely be determined by the cost of the coverage, he said.

For its land-based operations, Hilton generally carries a $100,000 self-insured retention for liability risks. The company would be prepared to have a similar or higher retention for the riverboats, Mr. Little said.

Riverboat casino operators also have seen liability premiums rise above their earlier low levels.

"Premiums have gone up as much as 50%," said Robert E. Ruebsam, vp and chairman of the gaming boat focus group at Sedgwick James Inc. in St. Louis.

Liability premium levels are set to be adjusted further during this year as underwriters become more experienced, he said.

"The market has not matured yet," Mr. Ruebsam said.

The premiums will also vary by state as each state has different regulations, he said.

For example, in Missouri, the vessels are required to remain at dockside. This means that they can be extremely large and hold more gamblers, so liability risks might be greater. The riverboat casinos are smaller in Illinois, but they have to be navigable, so there is a greater exposure to catastrophe risks, Mr. Ruebsam said.

In Louisiana, where the riverboats tend to be large and can be either dockside structures or navigable vessels, the casinos are exposed to hurricane risks, said Jerry Grim, vp of the marine department of Arthur J. Gallagher & Co. in St. Louis.

This large catastrophic risk has been a major concern of underwriters, said Hilton's Mr. Little.

"Underwriters were looking at the number of people and thinking, 'We've got a 747 on the water and if it goes down there is a huge liability exposure,' " he said.

To ease insurers' fear, Mr. Little visited underwriters in London and in the United States personally to explain the risk, he said.

"I had to explain the emphasis we put on safety and explain how we have worked with the Coast Guard right from when we started constructing the boats," Mr. Little said.

The Hilton coverage should be placed soon with underwriters in London and the United States, he said. J&H is the broker placing the coverage.

The huge volume of people that all the casinos handle sets riverboat casino risks apart from most other marine risks, brokers and underwriters agree.

The large barges can accommodate more than 1,000 customers at a time and the navigable boats carry hundreds of passengers on two- to three-hour gambling cruises, operating for up to 15 hours a day.

With alcoholic beverages served and many elderly customers on board, the probability of injuries sustained from slips and falls is great.

The average riverboat casino is likely to have between 400 and 500 incidents a year, and about 10% of those are likely to result in a liability claim, said Gallagher's Mr. Grim.

This is about 10 times the amount of personal injury claims that a normal pleasure boat operator would receive, he said.

Part of the reason for the high level of claims could be the nature of the casino business, Mr. Grim said.

"Despite what they might say, most people go on these boats expecting to win money, not lose it, and when they do lose, they may be more likely to file a claim" to recoup their losses, he said.

However, the sophisticated risk management practices of many of the operators are stemming these types of losses, said Steve Felker, a managing director in the St. Louis office of Marsh & McLennan Cos. Inc.

"We are very impressed with the companies we have dealt with and how well-run the vessels are," he said.

Many of the riverboat casinos have extensive video systems that can be tapped to help weed out bogus slip-and-fall claims, Mr. Felker said.

"People might say that they had a fall, and our client can ask them where and when they fell and then check the video to see whether it really happened," he said.

But not all of the operators are so well-managed, said Ronald Thornton, senior vp and regional manager at Marine Office of America Corp., a unit of Continental Insurance in Cranbury, N.J., that provides coverage for some of the gaming vessels.

"The people behind the operations range from professional casino managers to a couple of chiropractors and a doctor who have gotten together," he said.

And some of the poorly financed companies cannot afford the surveillance systems that their richer counterparts have, Mr. Thornton said.

"We see those that have closed-circuit TVs, but we also see those with nothing," he said.

The gaming boats present several new challenges for risk managers, said Kirk Jelinek, corporate director of risk management at Promus Co. Inc., a casino, entertainment and hotel operator in Memphis, Tenn.

Promus, an M&M client, operates one gambling vessel in Illinois, two vessels in Mississippi and has plans to launch several others in other states, he said.

Safety standards for the navigable vessels are set by the U.S. Coast Guard, he said. Some of the standards are more stringent than for land-based casinos, but others are not so tough, Mr. Jelinek said.

For example, requirements for watertight doors on vessels necessitate raised lower door frames, which are not required on land and increase the possibility of trips and falls, he said.

"We have had to install ramps and steps to overcome this," Mr. Jelinek said.

On the other hand, Coast Guard regulations do not require sprinkler systems, he said.

"Their regulations are more concerned with seaworthiness, but we think that sprinklers are necessary, so we have installed them," Mr. Jelinek said.

He declined to give details of Promus' coverage.

Risk managers used to buying business interruption coverage from property underwriters face difficulties when they buy the coverage for the gambling vessels from marine underwriters, said M&M's Mr. Felker.

Most marine business interruption risks are valued as a percentage of the hull value, but the loss-of-hire risk for a gaming boat worth $10 million might be five times the value of the vessel, he said.

"So, if underwriters try and apply the same pricing mechanism for a gaming boat as they would for a tanker, the premiums go out of sight," Mr. Felker said.

To overcome this, M&M uses a combination of marine and property underwriters when putting together a coverage program for a riverboat casino client, he said. So, although the business interruption coverage would fall under a marine policy, it would be covered with wordings similar to a property coverage form, he said.

"The property underwriters understand some aspects of the risk better," Mr. Felker said.

Determining when the coverage should kick in was also a problem, said Mr. Little.

Marine business interruption deductibles are often for 30 days, he said.

Hilton wanted a much shorter time frame for its business interruption deductible than would traditionally be given in the marine market, Mr. Little said.

The company is still negotiating the deductible, but it is likely to be fewer than 10 days, he said.

Still, risk managers are not yet wholly satisfied with the coverage that is available to riverboat casinos, said Mr. Jelinek.

"The marine insurance industry is steeped in tradition, and it can be difficult to get changes to the policies," he said.

For example, the underwriters are unwilling to cover the risk of customers being unable to travel to the boats due to bad weather conditions, such as the flooding that waterlogged much of the Midwest during the summer of 1993.

"That is the kind of coverage extension that we are still looking for," Mr. Jelinek said.

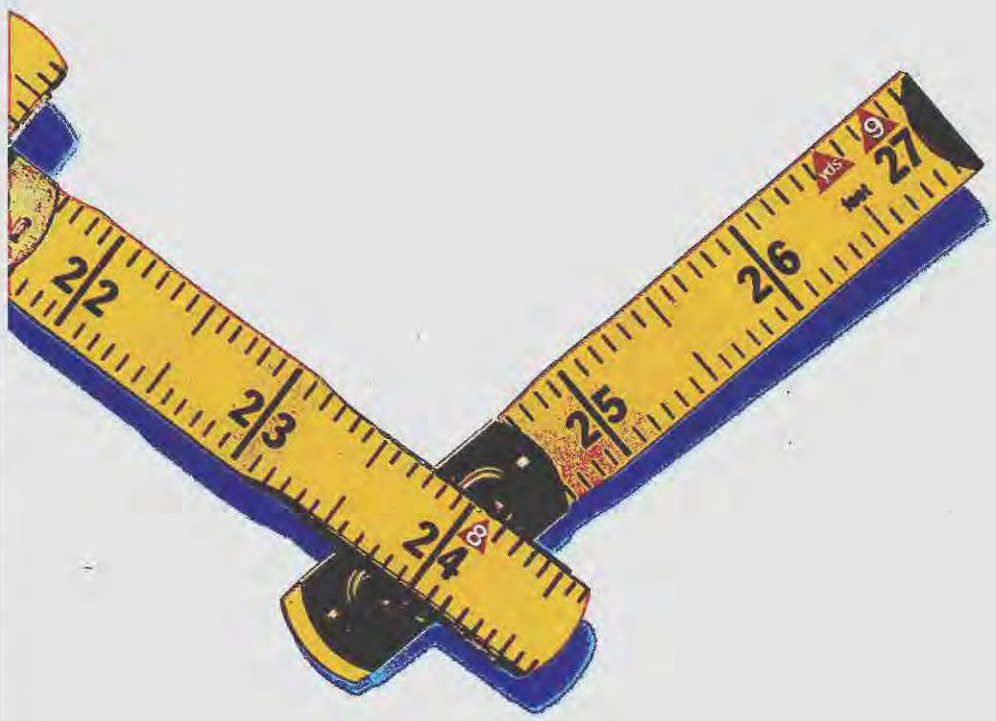
But it is not just the customer and gambling risks that underwriters and risk managers are concerned about. The number of employees on board is also unusually large.

The navigable vessels can have between 150 and 300 employees on board. As the boats leave the dock, compensation for employee injuries is governed by the Jones Act, a federal maritime law, rather than state workers compensation statutes, said Gallagher's Mr. Grim. Benefit payments under the Jones Act are likely to be higher than state workers comp laws because the Jones Act does not include a specific schedule of benefits and every claim can be litigated by the injured workers, he said.

"If you are not careful, you could face a lot of lawsuits," Mr. Grim said.

But, despite the new difficulties facing underwriters, insurance for gaming boats could be a significant revenue-earner, he said.

"There are a lot of boats on the drawing boards, and we expect to see a lot of activity over the next four or five years," he said. BI



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Milliman & Robertson acquires Betterley

WORCESTER, Mass.—Actuarial consulting firm Milliman & Robertson Inc. has acquired risk management consultant Betterley Risk Consultants Inc.

Richard S. Betterley, formerly president of Betterley Risk Consultants, will head the new Betterley Risk Management division of Milliman & Robertson.

The division's headquarters will be in Betterley's offices in Worcester, Mass. Betterley's nine staff members will join the 900 U.S. employees of Milliman & Robertson.

The acquisition adds risk management consulting to the actuarial, employee benefits and management consulting services offered by Seattle-based Milliman & Robertson.

Betterley provides risk and insurance reviews, alternative risk financing programs and risk management planning to publicly and privately held companies, nonprofit organizations and government agencies.

The two companies had worked together on projects for several years, Mr. Betterley said. "We find our clients seeking a broader range of services that go beyond our traditional risk management consulting into areas that can be well-served by Milliman & Robertson consultants," he said. "Joining Milliman & Robertson is a very natural step for us to take."

Terms were not disclosed.

Excess comp cover

CHICAGO—Excess workers compensation insurance for large self-insurers is now available from Wexford Underwriting Managers Inc., a subsidiary of Aon Risk Services Inc. Continental Casualty Co., a unit of CNA Financial Corp., will underwrite the coverage. The coverage is available in statutory limits or for other limits specified by the employer.

To be eligible, a company must self-insure, either individually or through a group, and retain at least $250,000 in losses.

New wholesaler

MINNEAPOLIS—National Benefit Resources Inc. has acquired Stop Loss International Corp., an Indianapolis-based marketer and underwriter for excess risk insurance for self-insured employee benefit plans.

The combined company is believed to be the largest managing general underwriter of excess risk in the United States, with 2,000 employer groups and more than 600,000 employees.

Gene R. Stevens, formerly regional vp of National Benefit, has been named president of Stop Loss International. Former Stop Loss International owner and Chairman Laurence B. Day and former President Sharon L. Day have been retained as consultants to assist with the transition.

Rehab care network

NASHVILLE, Tenn.—Rehability Corp. has acquired eight outpatient rehabilitation centers that collectively generate annual revenues of more than $6 million.

Jewett Orthopedic Clinic in Orlando, Fla., is the largest acquisition, with four outpatient physical therapy and sports medicine clinics.

Hand Therapy Services has two centers and is affiliated with a hand surgery physician group in Charleston, S.C.

Other acquisitions are Upstate Therapy Services Inc. in Greenville, S.C., and the Mid-Tennessee Bone and Joint Clinic in Columbia, Tenn.

Brentwood, Tenn.-based Rehability manages 146 rehabilitation centers in the United States.

Health care venture

MINNEAPOLIS—NWNL Health Management Corp. will provide comprehensive services for Criterion HealthCare Network, an independent, physician-owned and governed health care delivery system.

Under the agreement, NHMC will provide claims administration and other services to the 400-physician network.

Criterion will contract independently with employers, managed care plans and insurance companies, as well as participate in NHMC's HMO, NWNL Health Network.

Criterion consists of 60% primary care providers, as well as surgeons and other specialists.

NHMC is a wholly owned subsidiary of Northwestern National Life Insurance Co.

Munich Re purchase

MUNICH—Munich Reinsurance Co. will acquire the 26% of Hamburg-Mannheimer Versicherungs A.G. owned by Skandia Insurance Co. Ltd. for 450 million deutsche marks ($258.3 million).

Munich Re already owns 54% of the Hamburg-based life insurer. The remaining 20% is held by Allianz A.G. Holding.

Hamburg-Mannheimer will continue to operate independently.

Poe & Brown merger

TAMPA, Fla.—Poe & Brown Inc. has merged with Arch-Holmes Insurance Inc. of Hollywood, Fla., which specializes in construction bonding.

Arch-Holmes principals Gerry Arch and Michael Holmes will remain with the company. Poe & Brown is the 13th largest U.S. broker, with 1992 revenues of $87.8 million.

Dental cover venture

FOUNTAIN VALLEY, Calif.—PM Group Life Insurance Co. and Delta Dental Plan have entered into an alliance in which PM Group will underwrite group dental products using Delta's network of dentists.

The new plans will be marketed initially in California and are available on a fully insured basis to groups with five or more employees. Self-funded plans are available to groups with 50 or more participants. The plans cover diagnostic, preventative, basic and major services and with optional coverage for orthodontia.

NAMIC growth

INDIANAPOLIS—Two mutual insurance companies and one reinsurer have joined the National Assn. of Mutual Insurance Cos., bringing membership of the Indianapolis-based trade group to 1,242.

The new members are: Westland Farm Mutual Insurance Co. of Great Falls, Mont., Polk & Butler Mutual Insurance Co. of Osceola, Neb., and MAERP Reinsurance Assn. of Chicago.

New offices

The federal **Pension Benefit Guaranty Corp.** has moved its Washington headquarters to 1200 K St. N.W., Washington, D.C. 20005-4026; 202-326-4040.

The **International Assn. of Defense Counsel** has moved to 1 N. Franklin, Suite 2400, Chicago, Ill. 60606; 312-368-1494, fax: 312-368-1854.

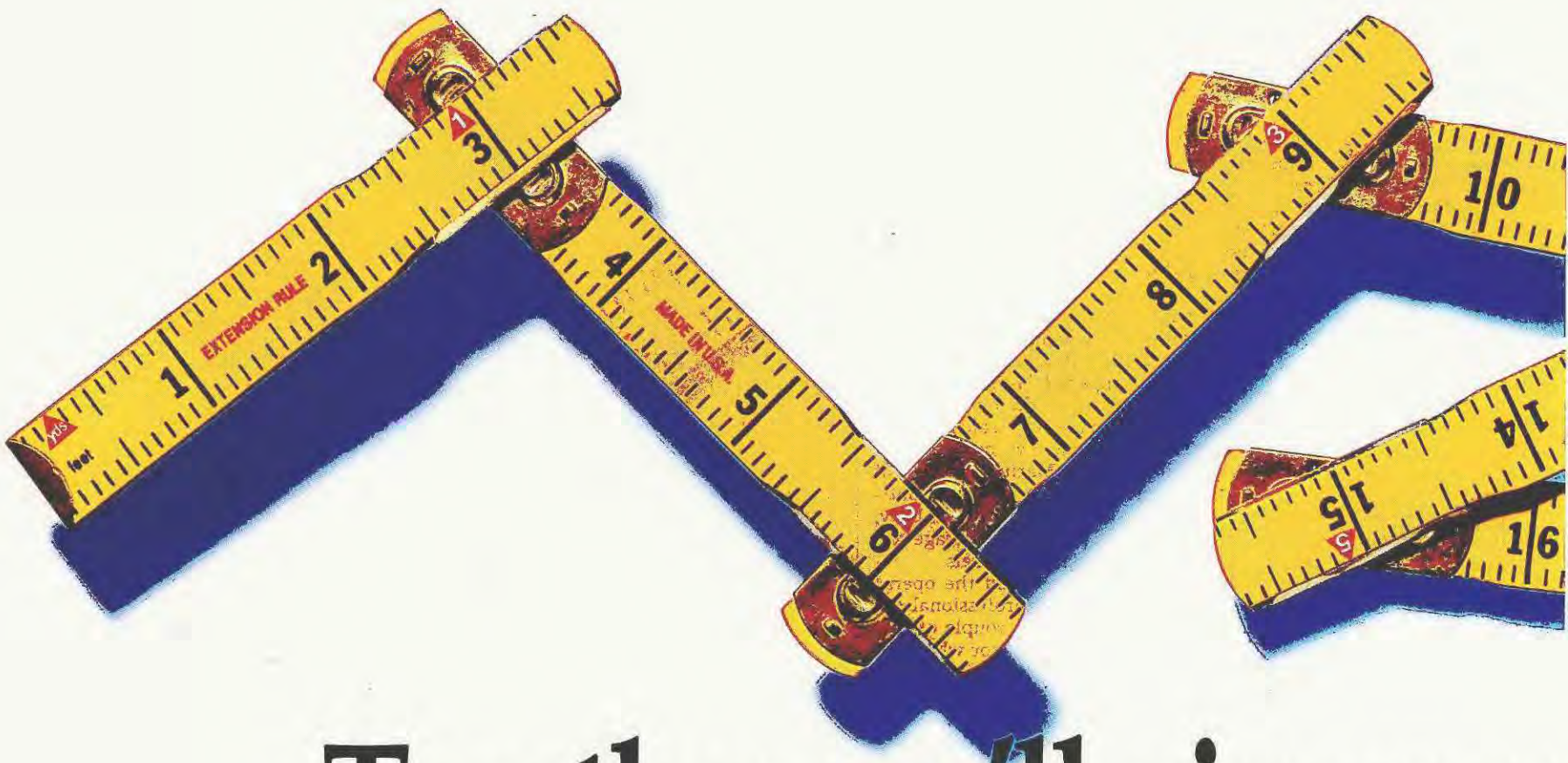
Law firm **Kroll & Tract** has moved to 520 Madison Ave., New York, N.Y. 10022-4235; 212-921-9100, fax: 212-869-3657.

Argonaut Insurance Co. has opened a new claims office at 1980 Post Oak Blvd., Suite 1710, Houston, Texas 77056; 713-622-0429, fax: 713-622-4896.

Dawson y Correa, an agency providing corporate insurance and surety in Mexico, has opened a U.S. office at 251 O'Connor Ridge, Suite 255, Irving, Texas 75038; 214-717-4959, fax: 214-717-5436.

Reliance National Insurance Co. (U.K.) Ltd. has opened a new Netherlands branch office at Beursplein 37, World Trade Center, 3001 DC Rotterdam, Netherlands; 31-10-405-1180, fax: 31-10-405-5092.

Unistrat P.A.R.I.S. has moved to 161-163 rue de Courcelles, 75017, Paris, France; 33-1-4429-9300, fax: 33-1-4766-7107. BI



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Age bias

Continued from page 1

pend on (age discrimination) claims," said Steven R. Merican, a partner at Rivkin Radler & Kremer. "Any company should have a system or mechanism in place before layoffs to handle the inevitable claims."

Age discrimination suits can prove especially costly. Average jury verdicts for age discrimination are 175% to 300% higher than those for sex, race or disability discrimination, according to Jury Verdict Research Inc.

The average age discrimination claimant from 1988 to 1992 was awarded $450,289 by juries, compared with $255,734 for sex discrimination, $176,578 for race discrimination and $151,421 for disability discrimination.

Why are jurors so sympathetic to age discrimination?

"(It's) one type of discrimination everyone can relate to," suggested Ms. Bryson. "Not everyone is a woman, or black, but everyone will be old one day."

Jury trials have been available in age bias suits since the ADEA was first put on the books in 1967. By contrast, people claiming discrimination based on race, sex, religion and national origin have only been entitled to jury trials since the Civil Rights Act of 1991.

Experts recommend companies take these steps to ensure that they do not discriminate against older workers:

• Make sure layoffs are only for "legitimate business purposes."

"Companies need to make sure they are (laying off) for a legitimate business purpose, not as a pretext for getting rid of someone," Ms. Bryson said.

Legitimate business purpose may be easier to prove when an entire department is being eliminated, rather than a percentage of the overall workforce. For example, a mainframe computer department might be eliminated because the system is outdated and the company is replacing it with personal computers.

• Beware of hidden bias.

"If you decide to get rid of 10%, it's really important how you decide," Ms. Bryson said. "I won't say it's necessary to preserve the racial and sexual balance (of the workplace), but it's important to be aware of that. The goal is to keep the best-qualified people and to evaluate in a race-neutral and sex-neutral environment."

After an initial list of layoff candidates is determined, companies should inspect it to determine if members of any protected class predominate. If they do, there may be hidden bias in the selection process.

Using a strict seniority system—outside some unionized workplaces where it might be mandated by collective bargaining—also may also present discrimination problems and may leave employers without workers with the most up-to-date technological skills.

• Make sure the process is perceived as fair.

"The more work that is done on the front end identifying people who are really not needed for a legitimate business criterion, the less likelihood of a lawsuit," Ms. Bryson said. "The most important thing is that employees perceive the process has been fair."

Some companies actually mention the possibility of future layoffs in their company handbooks. Typically, companies promise that any future cuts will be made fairly.

Some companies also release information about possible layoffs in stages over a long period. That may minimize feelings of betrayal by giving employees lots of warning and may convince some employees that the company considered options other than layoffs.

One major manufacturing concern began informing employees about changes a year before the first pink slips went out.

First, said Ms. Bryson, the company acknowledged that tough times had forced it look for ways to improve productivity. Then it told employees that studies had shown some jobs would have to be cut. Finally, it told employees that the cuts would be based on which jobs were needed most. Company-wide performance evaluations followed, which ultimately led to transfers and some layoffs.

Age bias is 'one type of discrimination everyone can relate to,' says Cheryl Blackwell Bryson.

By contrast, Ms. Bryson said, "Companies that give little thought to managing their communications are more likely to be involved in litigation."

• Permit employees to appeal.

Appeals are generally informal and handled by the human resources department.

"Companies are smart to dispel rumors and allow employees to challenge and raise questions," said Ms. Bryson. "Most Fortune 500 companies allow employees to come in and talk. It makes sense."

That's a lesson some companies have only learned the hard way. Some companies, she said, have not allowed employees let go in the early rounds of layoffs to appeal. But, in later rounds of layoffs, after being hit by class-action discrimination suits, they decided to permit appeals.

• Carefully document window plans.

Companies should document that their plans are voluntary and that employees have at least seven days to consider them, said Howard Golden, a partner with Kwasha Lipton in Fort Lee, N.J.

• Be careful about requiring employees to sign waivers not to sue.

Employers requiring employees to sign a waiver giving up rights to sue the company must provide at least 21 days for consideration.

One company that may have misused waivers is Sears, Roebuck & Co.

In a recent suit, the EEOC charges that Sears did not allow employees enough time before signing the waiver. "The EEOC alleges that Sears violated the ADEA by conditioning receipt of severance benefits on the execution of a waiver and release," said Gregory M. Gochanour, an EEOC attorney in Chicago.

The EEOC is asking a federal court to declare the waivers Sears has received since February 1992 invalid, as well as require the retailer to re-offer the package to eligible employees who did not accept it.

Sears, which has cut nearly 100,000 jobs since 1990, disputes the charges.

Most companies avoid using waivers because of the psychological impact on employees and because they do not always stand up in court, Mr. Golden said.

"You can wind up scaring an employee with the waiver when there is nothing underhanded going on," Mr. Golden said. "You have to look at who is the mix of employees and how will they react. The waiver is an arrow in the employer's quiver, but it does not necessarily have to be taken out."

• Beware of ERISA non-discrimination rules.

Companies that use financial incentives to induce employees to retire early can offer benefits through the regular company benefit or in some form of lump sum payments.

Most companies choose the former option.

Anheuser-Busch Cos. Inc., for instance, recently offered employees an enhanced retirement package as part of a campaign to reduced salaried workforce by 10%—or about 1,200 positions. The offer added five years of age and five years of service to the company's pension formula with a minimum 15% improvement over the standard retirement package (*BI*, Oct. 11, 1993).

Companies that make payments through existing plans should be careful to comply with Internal Revenue Service non-discrimination rules.

But making payments outside

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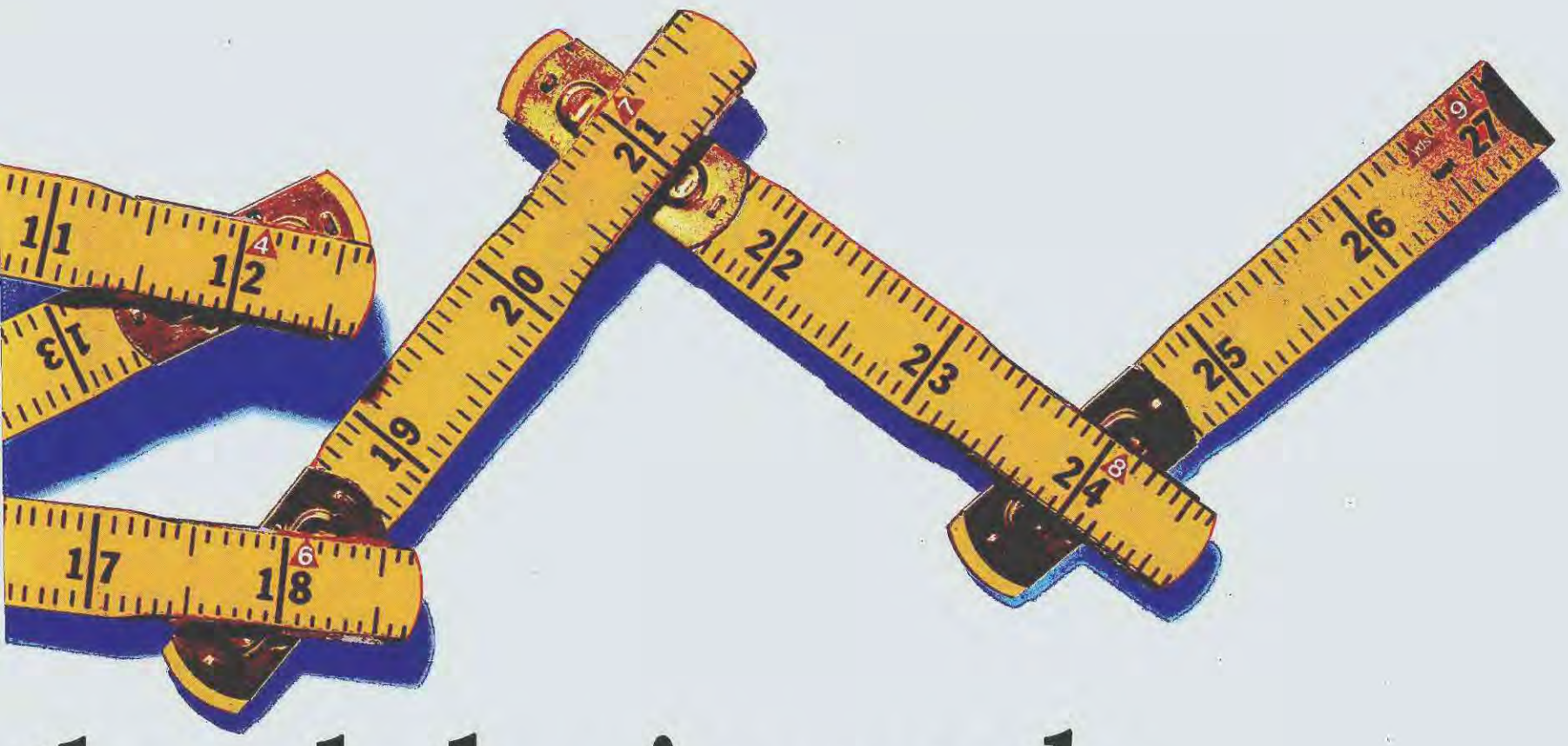

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Age bias

Continued from previous page
an existing benefit plan does not ensure that companies can avoid the non-discrimination rules. Especially when 5% or more of the workforce is involved, the Department of Labor could well enforce the rules even for payments outside an ERISA plan.

"Employers may bite the bullet and have a plan that looks like an ERISA plan," Mr. Golden said.

When age discrimination lawsuits are filed, some employers are finding coverage under employment practices liability policies purchased in recent years (*BI*, May 31, 1993; March 23, 1992).

But more and more of the claims are falling under general liability policies.

"Plaintiffs' lawyers are looking for a way to fashion complaints to reach into insurance coverage," Ms. Bryson said.

Discrimination is generally not covered under commercial general liability policies because it does not involve property damage or bodily injury.

However, Mr. Merican noted, some courts are ruling that mental distress is a "bodily injury," which could trigger coverage under a standard CGL policy.

And, some age discrimination claimants are including common law torts like negligence and slander in the their complaints in addition to violation of their civil rights. Those allegations may be covered under a personal injury endorsement to the CGL policy.

"That's where the battleground of the future will be," Mr. Merican predicted.

Smaller and midsize companies are more likely to buy employment practices policies than larger companies.

"Large companies probably have a large, sophisticated human resources department," Mr. Merican said. "They are probably a little more savvy than smaller and midsize companies. They've been around the block before.

"With a few glaring exceptions, these cases don't involve super large numbers. Big companies can lay off the risk easier," he said.

"Employment discrimination of all kinds is the biggest part of the explosion of the federal court docket," Mr. Merican said. "It's become an important part of a lot of companies' risk management component."

Despite the increase in age discrimination liability exposures and in the insurance available for it, risk managers are often left out of layoff discussions, said Thomas V. Ealy, vp of Alexander & Alexander Inc. in Chicago.

"With the continued wave of corporate restructuring and re-engineering, from an employment risk management standpoint, the benefit to firms of involving risk management professionals is greater than ever," Mr. Ealy said.

"I'm concerned about (age discrimination) as a risk manager, but most of the activity is contained within the human resources department," said Dennis Slabaugh, corporate risk manager at Community Health Care Inc. in Naples, Fla.

That is slowly changing as the Family & Medical Leave Act, the Americans with Disabilities Act and publicity regarding sexual harassment bring employment liability to the forefront.

"We are actively looking at either an individual policy or an endorsement to our directors and officers policy to cover employment practices," Mr. Slabaugh said. BI

HCFA bills

Continued from page 1
plans became the primary payer of health care for employees who stayed on the job after 65. Medicare became the secondary payer.

Those laws also made employer plans the primary payer for some non-elderly employees with permanent kidney failure and certain other disabilities for which Medicare had been the primary payer.

Congress passed those laws to save the Medicare program billions of dollars. But those savings were not realized because Medicare continued to pay claims for some beneficiaries who were no longer covered primarily by Medicare—generally workers over 65 and their spouses.

Congress, concerned that anticipated savings had not materialized, gave the HCFA authority, in conjunction with the Internal Revenue Service and the Social Security Administration, to search payroll records and identify individuals with employment-related income after they turned 65.

As part of the Data Match program, HCFA sent letters to 750,000 employers, asking whether they had group health plans. HCFA later sent letters to employers asking if specific individuals were covered under their group plans.

In the current and last stage of the Data Match program, HCFA bills generally have been sent to TPAs and insurers. Employers only receive bills if they self-administered their self-insured health care plans.

Early on, benefit experts warned that plan administrators should carefully scrutinize the HCFA bills, which have been sent out by about 80 HCFA contractors. They warned that the bills could involve claims that were properly paid years ago or that the bills could be inflated.

Both predictions have been on the mark, plan administrators say.

For example, Donna McQuillen, director of technical services at Sedgwick Noble Lowndes Administrators in Newtown, Pa., says about 40% to 50% of the HCFA demand letters involve claims that the company actually paid back in the 1980s.

Other TPAs say the bills have been inflated. For example, Ms. Meyer of Harden & Co. says the firm has received claims totaling more than $130,000 from HCFA. After researching records, the TPA found that about only $20,500 in claims were bona fide.

Other TPAs also report inflated claims, though the discrepancies haven't been as great. For example, a spokeswoman for Payflex Systems USA Inc., an Omaha, Neb.-based TPA, says the firm's HCFA claims to date total about $57,000, of which about $30,000 are legitimate, it says.

TPA and HCFA officials both say there are a number of reasons why bills are being sent out for claims that were properly paid years ago and why the bills may be inflated.

In some cases, a hospital or other provider may have double-billed, billing both Medicare and the employer plan for an older worker's treatment for which the employer plan was the primary payer.

While both parties reimbursed the hospital, HCFA might not have information that the employer plan also paid the claim at the time. After TPAs supply evidence that they, in fact, paid the claim years ago, HCFA will seek recovery from the providers.

HCFA demand letters often are inflated because the agency doesn't know that certain portions of an older worker's hospital or physician's bill may not have been covered by the employer plan, because, for instance, of plan deductibles or coinsurance requirements.

In other cases, employers filling out HCFA questionnaires may have made mistakes, indicating, for example, that an older worker or dependent was covered by an employer plan years ago, when they were not.

If bills are inaccurate, plan administrators should send a copy of the explanation of benefits paid to the beneficiary or the provider.

Meanwhile, TPAs say they have not had resistance from clients when they explain they owe money on claims incurred many years ago.

"We have warned clients that employer plans were primary. They have been pretty understanding," said Harden & Co.'s Ms. Meyer. Generally, in the case of self-insured companies, employers typically will transfer funds to the TPA and the TPA then will issue a check to the HCFA. BI

"Suddenly, I was getting calls about pensions, health insurance and 401(k) plans ...

Maureen Ruelas
Human Resources Representative
Talley Defense Systems

"Last year, when our benefits administrator retired, I was given responsibility for Talley's benefits programs. From day one, I began to receive calls from employees asking for information and advice about their insurance and retirement plans. I knew parts of the answers, but I realized I needed additional training in benefits management and I needed it fast!

My supervisor suggested that I look into the CBP (Certified Benefits Professional) seminars that are available from the American Compensation Association (ACA).

My immediate challenge was calculating pensions and dealing with 401(k) plans. What I needed was an overview of the entire process, from beginning to end. I needed to know how to talk about pensions and 401(k) plans with our employees and managers.

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Trinity Insurance Company Limited

Initial Payment to Creditors

A Scheme of Arrangement was approved by the creditors of Trinity Insurance Company Limited and subsequently became effective on 18 March 1993, after receiving High Court sanction.

Pursuant to the terms of the Scheme, the Scheme Administrator, Richard Boys-Stones and Colin Bird of Price Waterhouse, have set the 'commencement date' on 6 January 1994 and the 'Initial Payment Percentage' at 10%, with the support of the Creditors' Committee. Scheme Creditors of Trinity with established claims at that date will be paid the initial payment percentage on those claims within 60 days of the commencement date. Thereafter, the initial payment percentage will be paid within 60 days of each claim becoming established.

Claims should continue to be agreed with Trinity and If creditors require more information please contact:

Trinity Claims Department
TMS 1992 Limited
Russell Street
Gloucester GL1 1EL.
Tel: 0452 528691.
Fax: 0452 301387.

Full details of the Scheme are available from the Scheme Administrator, Price Waterhouse, No. 1 London Bridge, London SE1 9QL.
Ref: RCB/MCR.

Price Waterhouse

INTERNATIONAL

Australian fires won't burn reinsurers

By KATE McILWAINE and ADRIAN LADBURY

SYDNEY, Australia—Insured losses from brush fires that have burned approximately 1.5 million acres of the Australian state of New South Wales are estimated at $150 million Australian ($69.1 million to $103.6 million), sources in Australia and London say.

The losses are not expected to hit international reinsurance markets.

While international television coverage has shown dramatic footage of the blazes that began in late December, insurers say the February 1983 "Ash Wednesday" fires were far worse. Those fires burned bush land, country towns and rural properties in the states of South Australia and Victoria. According to the Insurance Council of Australia, the revalued insured cost of the '83 fires totaled about $280 million Australian ($251.9 million at the appropriate exchange rate).

"In the intervening period, and especially over the last three years, the attachment point of Australian catastrophe programs has risen significantly and would now represent between 10% and 15% of property income," according to a statement made last week by the Australian branch of Lloyd's broker Greig Fester Ltd.

Claims already have been filed from the fires that have burned in several national parks along the coast of New South Wales and in metropolitan Sydney, killing four people. However, no major commercial claims have been reported yet, insurers say.

Claims filed so far are predominantly for homes and cars, with Sydney-based insurers GIO Australia Ltd. and NRMA Insurance Ltd., a unit of the National Roads

Continued on next page

The brush fires that have raged along the coast of New South Wales have hurt owners of luxury homes in suburban Sydney and other homeowners far worse than businesses.

GRAPHIC BY JOHN HALL

Commercial Union hit with record fire claim

SYDNEY, Australia—Commercial Union Ltd. was hit with its largest individual claim in 30 years from a blaze in a suburban Sydney printing factory that occurred only days before the recent Australian brush fires began.

The gross insured loss is $62 million Australian ($42.8 million). The cause of the fire is unknown.

Melbourne-based Commercial Union Ltd. underwrote 33.3% of the coverage for the printing plant. The rest of the coverage was written by seven other insurers. The plant was owned by Offset Alpine Printing Ltd., based in Silverwater, west of Sydney.

Philip Clairs, managing director of Commercial Union, said replacement printing presses have been ordered from France in a bid to keep business interruption costs to a minimum.

—By Kate McIlwaine

Jim Payne leaves Sedgwick

By STACY SHAPIRO and ADRIAN LADBURY

LONDON—Jim Payne, a major figure in the London reinsurance community, is retiring as vice chairman of Sedgwick Group P.L.C. on March 31.

This move follows his Dec. 31 retirement as chairman of Sedgwick Payne, the firm's specialty insurance and worldwide reinsurance brokerage operations based in London. Sedgwick Payne includes E.W. Payne Ltd. in London and Sedgwick Payne in the United States.

Jonathan Gilbert, formerly managing director and deputy chairman of Sedgwick Payne, has become chairman of the division.

London market sources question whether Mr. Payne, 56, was asked to leave Sedgwick due to poor results in its reinsurance operations in recent years. Although Sedgwick Payne's reinsurance revenues grew 6.3% in the first quarter of 1993, the rest of Sedgwick Payne did better, growing 20.3% (*BI*, July 5, 1993).

Before the group's restructuring early last year, E.W. Payne saw 1992 revenues drop 7.3% to 63.1 million pounds ($95.6 million) from 68.1 million pounds ($127.3 million) at the end of 1991.

But Mr. Payne denies that poor results in his division or politics within Sedgwick played a part in his decision to leave the board.

Mr. Payne told *Business Insurance* that he decided to retire because he wanted to move away from executive responsibilities and return to his favored specialty: reinsurance. Never one to fit naturally into a big corporate structure, he said, "I want to have some fun again, frankly. I absolutely adore working with people, and I don't think that reinsurance is (just) a commodity business."

Mr. Payne plans to continue working in the London market as a consultant and as a board member of Lloyd's corporate capital investment trust CLM Insurance Fund.

LONDON

Lloyd's capacity

Two large Lloyd's of London corporate capital investment trusts have announced that they have snapped up more than 30 million pounds ($44.8 million) of "spare" capacity that was reserved for corporate trusts that ultimately failed.

But neither trust has used its full potential capacity allocation and, according to one of them, this is simply because there isn't enough quality capacity to accommodate their potential to invest.

London Insurance Market Investment Trust P.L.C., the biggest of all the new trusts, with capital of 280 million pounds ($421 million) and potential underwriting capacity of 560 million pounds ($828.5 million), has announced that it has secured aggregate underwriting capacity of 502.5 million pounds ($743.5 million) for 1994.

This is 22 million pounds ($32.5 million) more capacity than the 480 million pounds ($710.2 million) for which it originally had agreements with managing agents when it released its prospectus last November.

Abtrust Lloyd's Insurance Trust P.L.C., the 11th-largest of the trusts quoted on the London Stock Exchange, with 30 million pounds ($45.1 million) capital and a potential capacity allocation of 60 million pounds ($88.8 million), has announced that it has arranged 38.3 million pounds ($56.7 million) of underwriting capacity for this year.

The managers of ALIT have increased their capacity allocation by 8.3 million pounds ($12.3 million) compared with the 30 million pounds ($44.4 million) they had secured with managing agents when their prospectus was published.

Most managing agents originally overallocated capacity to the corporate vehicles in the belief that not all would raise enough cash in time for the 1994 underwriting year, but it seems that many managing agents had excess capacity available for those that did make it.

A statement released by LIMIT last week said it was ready for a possible surplus of capacity. It also stated that 44 million pounds ($65.1 million) of capacity had not yet been allocated to support specific syndicates.

Lloyd's names sue

Two Lloyd's of London names are suing their members agency, KMR Services Ltd., for placing them on catastrophe excess-of-loss syndicates that were "unnecessarily risky," according to testimony presented to Britain's High Court last week.

In a test case, the two names are trying to recover damages of more than 2 million pounds ($3 million) against the agency, formerly known as H.G. Poland Agencies Ltd. If they succeed, then more than 30 other members awaiting trial could succeed in their efforts to collect a total of 50 million pounds ($75.18 million) in damages from their members agencies, according to the plaintiffs' lawyers.

Justice Saville last year selected these two cases to be tried first out of all the "portfolio selection" litigation in progress. All the cases involve allegations of negligence in members agents' selection of a portfolio of syndicates in which the members would invest.

One of the plaintiffs, Yorkshire businessman Richard Brown, has been a member of Lloyd's since 1977, and over the years substantially increased his premium income limit, which reached 1.3 million pounds ($2.4 million at the appropriate exchange rate) for the 1989 underwriting year, the High Court heard last week.

Mr. Brown earned profits through the Poland members agency until 1988, when he started

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European downpours raising flood losses beyond $900 million

By ALINE SULLIVAN

Heavy rains continue to cause flooding in Western Europe, causing insured losses to rise to more than $900 million and pushing uninsured losses to several times that amount, insurers estimate.

Flooding began in Britain on New Year's Eve, several weeks after heavy rains first hit several areas of continental Europe (*BI*, Jan. 3).

Across western Europe, the ongoing deluge is shaping up as the region's worst flooding in almost 100 years. At least five people have been killed and thousands of people have been evacuated from homes and businesses.

Rivers and canals remained swollen in Britain, France, Germany and the Netherlands last week, while thousands of acres of farmland are under water.

If heavy rains continue this week, as forecast, damage is expected to increase in Britain and France.

Insurance companies in Britain will be liable for about 60 million pounds ($89.4 million) in flood damage claims, a spokesman for the Assn. of British Insurers said last week. Flood damage is typically covered under commercial and personal property insurance policies in Britain.

About 135 flood warnings have been issued throughout southern England, following seven inches of rainfall in the first 10 days of January. The usual monthly rainfall is five inches.

Most damage in Britain has been in rural areas. However, the southern city of Chichester was expected to be badly hit by flooding late last week.

"Rainfall is continuing in many parts of the country, and it will be several months at least before we can tot up the final damage figures," said the ABI spokesman, adding, "The insured costs could be much higher."

Insurers pointed out, however, that insured losses from flooding tend to be much less than from damage caused by windstorms.

Lloyd's of London underwriters will probably have to pay out less than 100 million pounds ($149 million) in claims as a result of the flooding in Britain and continental Europe, said a spokesman for the Corporation of Lloyd's.

"Most of the damage has been to farmlands, which are not usually insured in the commercial market," the Lloyd's spokesman said. "Our involvement will be confined to homeowners and auto policies. Claims from these should be very limited, because much of the affected property just dries out."

Damage in continental Europe, where flooding began around Dec. 21, has been far more severe than in Britain. National and local governments have declared states of emergency in many low-lying areas and have pledged substantial monetary assistance to help farmers and residents recover uninsured losses.

In France, estimates for insured damage from recent floods have risen to 4 billion francs ($676 million) as of last week, up sharply from 3 billion francs ($507 million) in insured damages estimated at year end by the Federation Francaise des Societe d'Assurances, a French insurance trade association.

The situation in France worsened last week when torrential rains hit the Carmargue region of southern France, where more than 7,400 acres of farmland are under water. Further north, the Seine and Rhone rivers continued to rise and both reached record high water marks.

A spokesman for the FFSA said that about half of French insurers' losses are reinsured through the state-owned reinsurance company, Caisse Centrale de Reassurance. The reinsurer maintains a natural catastrophe reserve fund that is financed by a 9% levy on all French non-life policy premiums.

This system of indemnification for natural catastrophes has not been jeopardized by the recent

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Fires

Continued from previous page
& Motorists' Assn., sharing the majority of them.

Figures released Jan. 12 by the ICA, a Melbourne-based organization representing major Australian insurers except GIO Australia, showed that of 900 claims filed so far, fewer than 200 were total losses of homes

While the ICA said no major commercial claims have been filed yet, Greig Fester said the losses include five factories, two gas stations and three nursing homes.

Additional commercial claims from golf courses also are expected, said Terry McMullan, public affairs manager for the ICA.

When the fires reached Sydney Jan. 6, many feared the insured loss could reach $1 billion Australian ($690.6 million), but light rain halted the fires' progress.

Owen Roach, executive director of GIO General, a unit of GIO Australia, said the brush fires are "a non-event financially." By late Wednesday, GIO had received fire claims totaling $7.5 million Australian ($5.2 million), and he expected them to reach $15 million Australian ($10.4 million) when all claims are filed. GIO's market share is between 15% and 20%, sources say.

"This is tiny, compared to other disasters," Mr. Roach said. For example, GIO paid out $150 million (Australian) gross ($118.5 million) in claims after the December 1989 Newcastle earthquake. Total losses for the quake totaled about $1 billion Australian ($790 million) (*BI*, Jan. 8, 1990; Jan. 1, 1990).

"We pay out an average of $4 million Australian ($2.8 million) every working day," Mr. Roach said. "Every year we expect a loss of this magnitude, and in some years a bigger one, like Newcastle. If it's more than $30 million Australian ($20.7 million), we collect from our reinsurers," he said.

"With high temperatures and high winds, after 10 years of no major fires, it's a fact of life in Australia" that there will be brush fires, Mr. Roach said.

But many homeowners are underinsured, particularly for building contents, he said.

ICA's Mr. McMullan said it is likely that less than 10% of damaged or destroyed homes are uninsured because the homes, particularly in Sydney's northern suburbs, are relatively expensive.

NRMA Insurance had received more than 348 claims by Jan. 13, approximately 89 for total loss of dwellings, totaling $12.5 million Australian ($8.63 million). Graham Edwards, manager of NRMA's loss adjusting division, said NRMA's total loss could reach between $15 million Australian and $17 million Australian ($10.36 million and $11.74 million).

The majority of claimants were underinsured between 19% and 30% for both contents and the property. NRMA has a 25% share of the New South Wales domestic insurance market, he said.

NRMA's catastrophe reinsurance program attaches at $30 million ($20.7 million), one source said.

A spokesman for Royal Insurance P.L.C. in London said that Sun Alliance & Royal Insurance Ltd., jointly owned by Royal and U.K. multiline insurers Sun Alliance P.L.C., would retain the first $15 million Australian ($10.4 million) of losses, and if that were exceeded, it has "several hundred million dollars" of reinsurance coverage in international markets.

But the spokesman said he does not believe the losses will exceed the company's retention.

A spokesman for General Accident P.L.C. said that its New Zealand subsidiary, New Zealand Insurance Corp. Ltd., would retain the first $10 million Australian ($6.9 million) of losses caused by the fires. Above that, it has reinsurance coverage, placed within the General Accident group in Australia, for the next $40 million Australian ($27.6 million). But the spokesman said he does not expect claims to exceed $10 million Australian.

London market insurers and reinsurers unanimously agreed that if the $150 million Australian prediction proves accurate, the majority of catastrophe reinsurance programs placed in international markets will not be triggered.

A Lloyd's catastrophe underwriter and many other London sources agreed with Greig Fester's Jan. 11 estimate that a marketwide property/casualty loss of about $250 million Australian ($172.7 million) among the local insurers would be required before the London, Bermuda, U.S. and other international reinsurance markets were hit.

ICA's Mr. McMullan said the insurance industry does not consider the current fires a catastrophe, even though the burned area was large.

Total losses for storms in Sydney since 1985 total $900 million Australian ($621.5 million), he said, noting that major storms occur every 12 to 18 months and are more serious, in monetary terms, than the current fires.

Paul Harrison, a partner in the Sydney loss adjusting firm Harrison-Gray Ltd., said losses are insufficient to trigger the insurance industry's emergency service procedures, which were put in place after the Newcastle earthquake. Under those procedures, loss adjusters and other insurance personnel in other states are on standby ready to go to a disaster scene to assist with claims handling.

The New South Wales government does not insure government-owned property but has a fund, managed by GIO Australia, called the Treasury Managed Fund, that has $10 million Australian ($6.9 million) in reserves.

Fire brigades won praise for the efforts in containing fire losses. The New South Wales government will begin public hearings in February as part of a previously scheduled inquiry into funding of fire brigades. Commercial and personal lines policyholders pay a 14% levy on top of their premiums to fund fire brigades. The insurance industry collects $170 million Australian ($117.4 million) a year, which accounts for 73.7% of the New South Wales fire brigade services' budget.

Mr. McMullan said there are inequities in the system. "Uninsured property owners contribute little or nothing to firefighting systems."

GIO's Mr. Roach said the fire services levy was a tax on those prudent enough to insure, and fire services should be levied on local property taxes. But he said it would be "politically inopportune" to raise the issue with the New South Wales government immediately after major fires. BI

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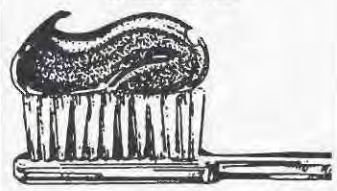

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DES

Continued from page 2

breakthrough," said Sybil Shainwald, a New York attorney representing the 11 women whose separate cases against three DES makers were consolidated in the New York court. "It validates these cases and should persuade other lawyers to take similar case."

Leroy Hersh of Hersh & Hersh in San Francisco, the plaintiffs' co-counsel, says the conditional award "shows pharmaceutical companies what a woman's right to her reproductive system is worth. DES for a long time has been known as a carcinogen. Now a jury has validated a woman's reproductive rights."

Defense lawyers, by contrast, argue that conditional damages are insignificant until the jury rules on the questions of liability and causation.

No matter how the jury answers those questions, the three firms could face only limited damage awards. Together, Emons Industries Inc., Carnrick Pharmaceutical Co. and Boyle Drug Co. of California had less than 4% of the national market when DES was sold from 1947 to 1971. New York courts have ruled that a DES manufacturer can only be held responsible for damages equal to its share of the market (*BI*, April 10, 1989).

"We're talking about very small amounts of money that are still subject to several important judicial steps before anything is recoverable," said Eric Statman of Anderson Kill Olick & Oshinsky in New York, which represents Emons. "Liability and causation are both issues that haven't been proved yet."

And even if Judge Gammerman instructed the jury to assess damages because he was certain that liability and causation ultimately will be proved, the defendants may end up paying only a small portion of the damages for each victim.

Based on a combined market share of between 3% and 4%, the three companies would owe the eight women suffering from fertility problems about $450,000 out of a potential $12.3 million award.

For the three cancer sufferers, who could be awarded a total of $32 million, Emons was not a defendant. Thus, Carnrick and Boyle, which together had less than a 1% national market share, would owe about $300,000.

For this reason, and because liability and causation are yet to be determined, other plaintiffs and defense attorneys downplayed the conditional damage award.

"The big players like Eli Lilly, Squibb and Upjohn don't even care about this case. These companies are bit players and the judge seems to have been seeking a guideline for settlements," said Ronald Benjamin, a plaintiffs' attorney based in Binghamton, N.Y.

Paul Rheingold, a plaintiffs' attorney with Rheingold & McGowan in New York, said more questions about the case must be determined before it will affect the hundreds of DES cases still pending in New York.

"These were small 'me too' companies that just did what the large manufacturers did. They're not Eli Lilly and they've never been found liable before. The best thing we can draw from this is that a jury would be willing to award relatively high sums for such cases," he said.

Still, Judge Gammerman's unusual approach—called a reverse trifurcation—may have sent a message.

"The case is no longer a crapshoot for the defendants," said Sheila Birnbaum, a defense attorney with Skadden, Arps, Slate, Meagher & Flom in New York. "It should cause them to seriously evaluate their causation defense" and consider settling.

"But still, there are too many question marks here to really say it's a precedent-setting award," said Ms. Birnbaum.

Mr. Benjamin agreed. "The court set some barometric numbers on infertility. It seems as though the parties now have some guidelines for a settlement."

But whether the parties will settle remains unclear.

Emons' position is that the company, which was named in only seven of the eight non-cancer cases, should have had its cases heard separately.

"Emons appealed the consolidation of the cases during pre-trial hearings. We felt that we could be prejudiced by being grouped with the more serious cancer cases. That appeal seems to be justified now," said Mr. Statman.

But Mr. Benjamin contends Emons may actually have benefited from being grouped in with the cancer cases. "It's possible that when compared to cancer, the jury actually awarded less to the infertility cases than they may have been worth had they been tried alone."

And, Boyle, whose lawyer did not return phone calls, litigated the case because it believes it has no liability based on the grounds that it never marketed DES in New York, according to Mr. Benjamin.

New York courts, though, have ruled that DES makers can be held liable to residents of the state even if they didn't sell the drug in New York (*BI*, April 20, 1992). BI

INTERNATIONAL

Flooding

Continued from page 31

floods, the spokesman said. Between the creation of the CCR fund in 1982 and the end of 1992, CCR had collected 34 billion francs ($5.75 billion) and had paid out 24 billion francs ($4.06 billion) in claims and expenses. No rise in the levy is expected as a result of the recent flooding, the spokesman said.

Insurers in Germany and the Netherlands won't be heavily affected by flood damage because they write little commercial flood coverage and personal lines policies exclude coverage for flood losses.

In the Netherlands, overall damage is expected to be "substantially" higher than the 15 million guilders ($7.7 million) estimated by the government in the first days of the flooding, said a spokesman for the Dutch insurance association, Verbond van Verzekeraars. He expects the government to pay about three times this amount to help affected residents and businesses.

"The flooding is starting to subside, but the experts are still looking at the damage and there have been no reliable estimates yet," the spokesman said. "Except for some cars, the insurance companies won't have to pay anything because all the damage is uninsured."

Flood coverage was excluded from Dutch property/casualty policies until about a year and a half ago, the Verbond van Verzekeraars spokesman said. Since then, no insurers have elected to provide the coverage. The Dutch government is considering a proposal by the country's fire insurers to establish a pool to cover some flooding claims.

In Germany, where the Rhine river and its tributaries have overflowed, damage estimates totaled about 1 billion deutsche marks ($574 million) as of last week. However, most of the damage is uninsured because few companies provide commercial or personal lines flood coverage. As in neighboring countries, the government has pledged assistance to affected businesses and residents. BI

LONDON

Continued from page 31

increasing his limit to more than 1 million pounds ($1.9 million). Poland chose high-risk syndicates for him, which in 1989 made up 52% of his entire portfolio. As a result, Mr. Brown lost more than 1.4 million pounds between 1988 and 1990 ($2.7 million).

Mr. Brown claims that he asked Poland to use a "conservative underwriting policy" when selecting a portfolio of syndicates. Instead, he was placed on syndicates of "exceptionally hazardous quality," Adrian Hamilton, Mr. Brown's lawyer, told the court. The agency was negligent and in breach of contract when it chose these catastrophe excess-of-loss syndicates, he argued.

However, the former Poland agency denies that Mr. Brown asked for a conservative underwriting policy. He was given all the syndicate accounts to read and could judge for himself the type of business being written, the defendant says. In addition, the losses weren't caused by a breach of duty by Poland, but by an unprecedented series of catastrophic losses never before experienced by Lloyd's, Poland claims.

But if the members win their actions, then Poland believes damages should be deducted to account for previous profits earned by the members at Lloyd's, tax rebates and personal stop-loss recoveries, according to court testimony.

The trial is continuing.

Airline insurance

Earned premiums in the airline insurance market still fall short of covering the cost of major losses in an average year, based on last year's statistics, a London-based airline analyst recently concluded.

Admittedly, airlines had an average year in 1993 for major hull and liability claims, Airclaims Ltd. said.

Major Western-built airline hull and liability losses increased 10% last year to a total of $817 million at year-end from $737 million in 1992. However, add $138 million for hull and liability losses from commuter aircraft and $5 million from Eastern-built airliners, and total losses amount to $960 million for last year, Airclaims added.

If attritional losses—partial losses and those unforeseen at the time of an accident—of an average of $300 million are added, total airline losses could amount to $1.26 billion for last year, the firm said.

But earned premium for the calendar year 1993, based on world rates, probably only totaled about $900 million, said Airclaims. "Based on these figures, earned premiums during 1993, despite recent increases in rates, still fall short of covering the cost of major losses in an average year and would need to be a good 40% higher to meet the cost of all losses," Airclaims said.

During 1993, 22 Western-built jet airliners were total losses costing $433 million, compared with 26 aircraft lost in 1992 costing $422 million. Last year there were also 42 major partial losses to Western-built jets totaling about $302 million.

A total of 422 passengers died in 10 fatal accidents last year. Early liability reserves for those killed and injured stand at $82 million. BI

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Outcomes

Continued from page 2

les office.

According to the survey, health plans don't believe that publishing results on medical outcomes will significantly help them in the marketplace.

For example, 69% of managed care plans said price is the first or second most important factor in marketplace success. By contrast, just 9% of managed care plans said publishing outcomes of medical treatments was the first or second most important factor for success in the marketplace.

Managed care plans generally acknowledge that outcomes research will improve the quality of medical care, but are less certain about its ability to reduce costs, the survey found.

Seventy-eight percent of managed care plans say outcomes research will improve the quality of care, while 15% thought it would have little or no effect. Five percent didn't know, while 2% said quality of care would actually deteriorate as a result of outcomes research.

Managed care plans were decidedly ambivalent on the impact of outcomes research on medical costs.

Thirty-three percent of plans said outcomes research would have little or no impact on medical costs, 30% said costs would decrease, while 22% said costs would increase and 15% didn't know how outcomes research would impact costs.

Providers, though, are more confident that outcomes research will reduce costs. Forty-six percent of providers said more efforts in the area of outcomes research would reduce medical costs, while only 14% thought costs would increase. Twenty-eight percent said outcomes research would have little or no impact on medical costs and 12% didn't know what the impact would be.

While a few employer groups—such as the Minneapolis-based Business Health Care Action Group (*BI*, July 13, 1992) and four large employers that make up Cincinnati's so-called Big Four (*BI*, April 12, 1993)—are demanding that providers and managed care plans provide more information on the outcomes of medical treatment, that demand isn't widespread, the Foster Higgins survey shows.

Thirty percent of managed care plans didn't receive any requests for outcomes data during the last year, and only 21% received a request at least once a month.

Given a general lack of employer demand, it isn't surprising that relatively few managed care plans provide information on medical outcomes, Mr. Meister said.

"Until there is more demand out there, providers and plans won't get serious about providing the information," he said.

In addition, employers would be "spurred to greater action if they saw a clearer connection between quality problems, such as unnecessary and inappropriate care, and high health care costs," he said.

While the enactment of health care reform legislation may ultimately force providers and plans to increase the amount of information on medical outcomes they collect, employers don't have to wait for that happen, he said.

"Employers need not wait for legislated reform to receive the benefits of outcomes research. They can require it—now. Health plans and providers who have begun developing the ability to measure and manage outcomes will be well positioned in the evolving health care market," he said.

•

Copies of "Survey on Outcomes Management," are available from Ann Marie Harte, A. Foster Higgins & Co. Inc., 125 Broad St., New York, N.Y. 10004; 212-574-9025. The cost is $50.

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* Source Business/Occupational breakdown of qualified circulation, May 31, 1993 issue, as submitted to BPA for June 1993 BPA Publisher's Statement.

Comp law

Continued from page 2

lot clearer."

Ed Woodward, president of the insurer-supported California Workers' Compensation Institute in San Francisco, observed: "It has been a very difficult process. The division had to respond to an immense package (of legislation) in a very short period of time."

The CWCI's "initial look" at the final regulations reveals that "significant changes. . .we were concerned about" were made, Mr. Woodward said.

A 40-member task force composed of employers, insurers and trade associations, led by the CWCI, analyzed and prepared comments on the draft regulations, Mr. Woodward said. "When you make that kind of investment, you are encouraged that you are not only listened to but responded to. The process has worked," he said.

In addition to attempting to curb the most costly components of the state's $11 billion-a-year workers comp system, the reform law—which Gov. Pete Wilson signed into law last summer (*BI*, July 26, 1993; July 19, 1993)—also allows small employers to band together to self-insure their workers comp risks. The law also makes it easier for the California Division of Occupational Safety and Health to crack down on employers with high-risk workplaces (see story, page 36).

Although many sources contacted last week had not yet seen the final regulations, several who reviewed a draft issued after the hearings agreed that the revisions resulted in improvements.

Mark Webb, senior counsel at the American Insurance Assn. in Sacramento, called the revisions "substantial improvements" over the first draft of the regulations.

Concerns of those who participated in the hearings "have been addressed but not necessarily solved according to our desire," said Joseph Markey, president of the California Self Insurers Assn. in Sacramento.

"But most notable is the fact that Casey Young tried to address the necessary issues. (The regulations are) a first run-through. The nice thing about regulations is if they don't work, we can fix them," Mr. Markey said.

Mr. Young said he intends to have an ongoing dialogue with employers, insurers and health care providers about the regulations, which could later be revised as the need arises, according to Mr. Webb.

In an interview, Mr. Young outlined the major changes he made in the regulations in response to concerns voiced at public hearings.

In the area of vocational rehabilitation, an internal cap of $4,500 on job counseling expenditures—contained within a $16,000 limit allowed for vocational rehabilitation plan costs—has been raised to $5,700.

"After the testimony, I was convinced that you need to invest more money up front in developing a good plan, where you've basically got one shot at it," Mr. Young explained.

Also under the final regulations, up to $1,200 can be spent on job evaluation alone—reflecting a $200 increase. Up to $2,500 can be spent on vocational rehab plan development and monitoring and up to $2,000 on job placement, he said. "You can, to some extent, move the money around to where

Continued on next page

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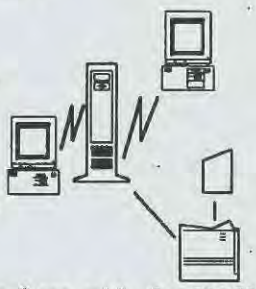

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Comp law

Continued from previous page
it is appropriate."

The final regulations also simplify the certification process for health maintenance organizations that wish to treat injured workers, Mr. Young said. Critics of the earlier drafts had complained that the process would prove too costly, boosting providers' administrative costs.

Under California's comp system, HMOs that treat injured workers are called health care organizations. The final regulations remove redundant administrative requirements from the certification process and let HMOs file less data.

"The revised HCO regulations will streamline the application process and clarify the relationship between the HCO and claims administrators in the area of loss control and workplace safety," the AIA's Mr. Webb agreed.

HMO executives had expressed concerns that the draft regulations made managed care organizations responsible for workplace safety, an area they said was not in their proper domain.

The final regulations also clarify which evaluations performed by physicians are regarded as "comprehensive medical evaluations" under the law, Mr. Young said.

The reform law is expected to reap some of its greatest savings through limiting costly medical-legal evaluations to one comprehensive evaluation per side in disputed cases.

The final rules also simplify recordkeeping requirements for self-insured employers, in response to concerns voiced at the hearings, Mr. Young said. BI

California reforms target workplace safety

By LOUISE KERTESZ

LOS ANGELES—California's workers compensation reform law not only limits costly treatments and evaluations of worker injuries, but also attempts to prevent some injuries altogether.

Among the provisions in the reform law are measures that: require insurers to provide state-certified loss control programs; expand worksite safety consultation by the California Division of Occupational Safety and Health; establish a targeted workplace safety inspection program; and allow small employers to band together to self-insure their workers comp risks.

Small employers in "homogeneous organizations"—for example, those in similar industries—may now band together to self-insure their workers comp exposures. The state Department of Industrial Relations is finalizing regulations governing pools of small self-insured employers, a DIR spokesman said.

Although it is an important change, that provision has been "a sleeper," observed Joseph Markey, president of the California Self Insurers Assn. in Sacramento.

Public entities in California and small private employers in other states are already allowed to pool their workers comp risks, he noted.

Mr. Markey said the proposed regulations require the following:

- The groups must have an aggregate net worth of at least $5 million and an aggregate profit averaging $500,000 per year over a certain period of time.
- The employers in the groups will have joint and several liability for their program's losses.
- The pools must have third-party administrators for their first five years of operation.
- The pools must have an acceptable injury prevention program and must become members of the Self Insurance Security Fund, a guarantee association.

The law also establishes targeted inspection and consultation programs by Cal-OSHA that will be funded by employers with high experience modification factors.

It requires Cal-OSHA to expand its consultation services "to pro-actively target employers with the greatest injury and illness rates and workers compensation losses," according to a legislative digest.

"How effectively these changes are developed and carried out by insurers and employers could result in a significant return on investment for employers and insurers," according to a report by Willie Washington, director of safety and health at the California Manufacturers' Assn.

Since employers will be footing part of the bill for the mandated safety programs, "we're trying not to get hammered," Mr. Washington said in an interview.

Also under the law, the California Insurance Code is being revised to incorporate the new requirements on insurers mandated by A.B. 110, according to Mr. Washington.

The law requires workers comp insurers to offer occupational safety and health loss control services certified by Cal-OSHA. These services, which must be provided at no cost to employers, would include workplace surveys, injury record reviews and injury prevention programs.

Insurers must also provide to the DIR "an annual health and safety loss control plan targeting employers with the greatest workers compensation losses, the most significant and preventable health and safety hazards, budget details and type and size of employer."

"DIR will be able to charge insurers a fee for certifying loss control consultants and reviewing insurers' annual loss control plans," Mr. Washington wrote in the CMA monthly report. "This is a very important change that focuses scarce resources where they are most needed, on small and medium-sized employers who lack the expertise to identify and develop the necessary corrective actions," he wrote.

A DIR working group is developing regulations to implement the insurer mandate, said Mark Webb, senior counsel at the American Insurance Assn. in Sacramento. The rules should go into effect April 1.

"Insurers feel positive" about the requirement to provide loss control services to policyholders, he said, noting that many insurers are already doing so. But, he added, "in a curious way, the one concern is that (the requirement) may have a leveling effect" on the competitive ability of insurers to offer different types of loss control products.

A.B. 110 also requires Cal-OSHA to establish an inspection and consultation program that targets employers in high-hazard industries with the highest incidence of injuries and workers comp losses.

"Insured employers with an experience modification of 1.25 or higher and private self-insured employers with an equivalent experience rating of 1.25 or higher will be assessed up to 50% of Cal-OSHA's budget to cover the program cost" of about $7 million, Mr. Washington wrote in the CMA report.

How the 1.25 modification factor will be calculated for self-insuring employers has not yet been determined, Mr. Markey explained. BI

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Oil spill

Continued from page 1

$10 million in liability, said Richard H. Hobbie III, president of the Water Quality Insurance Institute.

But OPA 1990 permits unlimited liability in many cases, such as if the pollution was caused by gross negligence or a violation of federal safety laws.

Sources say that the barge's hull coverage was placed by Eastern Marine Management Co., a brokerage and agency in New York. Its owner, Bob Farula, would not comment.

The Bunker Group leased and operated the tug boat from Metlife Capital Corp., a Bellevue, Wash.-based affiliate of Metropolitan Life Insurance Co.

Paul Graf, Metlife Capital's general counsel, said the Bunker Group had chartered the tugboat. He said the tugboat's insurance, including who bought it, is still unclear.

Nine tanks on the barge were damaged when the tow line snapped and the barge hit a coral reef. Inadequate repairs reportedly caused the tow line break.

Six miles of shoreline was polluted by the spill, though most of the oil was concentrated in a single half-mile stretch, according to the Coast Guard.

"Some of the beaches were pretty well soiled with heavy oil," said a spokesman.

Even though the barge was grounded on the reef, heavy swells caused further damage to it last week, leading to the release of still more oil, the spokesman said.

Heavy seas have also delayed efforts to remove the remaining oil from the barge.

AP/Wide World Photo

Pedro Rossello, governor of Puerto Rico, points toward the barge that polluted the waters off San Juan.

The oil spill occurred at the height of Puerto Rico's tourist season in an area notable for its luxury hotels.

One of the worst hit hotels, the Caribe Hilton, was transporting guests to a Hyatt hotel daily, along with its swimming and tennis staff.

A spokesman said the hotel had not decided whether to file a claim with its property insurer, Royal Insurance Co. of Puerto Rico Inc. "We're still evaluating that."

Owners of another hotel, the Radisson Normandie, are planning to join with the hotel's insurer, Osaco S.A. Seguros y Reaseguros of Madrid, Spain, to sue the tanker operator, said Miguel Perez, the hotel general manager.

The hotel still has to determine the number of cancellations and unexpected departures to fully evaluate the oil spill's impact, said Mr. Perez early last week.

Damage seemed less severe at the nearby Condado Plaza. Despite the "incredible" smell, "it would not appear this has any material effect on my business," said the hotel's president, Carl Kortum. "I'm trying to assess rooms canceled or whatever, and I'm really coming up with very little."

He will not rule out a lawsuit against responsible parties, though. Because there has been no physical damage to the hotel, its business interruption losses are not insured.

The Frank family, which owns Standard Tank Co. of Bayonne, has long been linked to toxic waste dumping in New Jersey and New York waters.

In 1990, a Frank company, General Marine Services, and company matriarch Evelyn Berman Frank, pleaded guilty to second degree charges of conspiracy for illegally discharging pollutants, said Mr. Madonna of the New Jersey attorney general's office.

Ms. Frank, who is in her 70s, was given probation because of her age and that same year removed herself from the two or three Frank companies that had New Jersey licenses. The firm itself was fined $1 million.

Another Frank company, Standard Tank Co., which shares an address with New England Marine Services, also has a long history of environment-connected litigation, said Mr. Madonna. Standard Tank, which had been in bankruptcy proceedings, was ordered liquidated by a judge earlier this month.

Last year, the company was fined $4 million for violating or exceeding water discharge permits and two Frank daughters, Susan and Jane, were individually fined $500,000 as well. The company's water pollution discharge permit was also lifted, requiring it to move its waste by truck.

"We've been systematically tightening the screws in any way we could to end their business dealings," Mr. Madonna explained. BI

Proposed rule would lessen oil cleanup costs

WASHINGTON—Companies found liable for oil spills would probably face lower cleanup costs under a National Oceanic and Atmospheric Administration proposal that calls for a "flexible and logical process for assessing natural resource damage" resulting from oil spills.

The proposal, which runs nearly 130 pages in the Jan. 7 Federal Register, rejects the idea of relying heavily on a "contingent valuation" technique to set a dollar value for certain types of non-economic environmental damage.

This technique uses public opinion studies to determine how much value should be assigned to natural resources that are damaged by an oil spill but are used "passively."

In its proposal, the NOAA calls for "a conservative approach in designing a contingent valuation instrument." In fact, NOAA says that officials should "choose the design that would understate the natural resource damage rather than overstate the damage."

Acting as a further brake on the impact of contingent valuation, the NOAA suggests discounting by half the value put on unspoiled resources by people surveyed.

The proposal further notes that at least one critic of the technique says measuring passive-use damages "could well cost the U.S. economy hundreds of millions of dollars annually by generating excessively high estimates of passive-use damages and could result in the bankruptcy of some responsible parties."

Some environmental groups have already complained that the NOAA proposal is too lenient and would allow some polluters to escape paying the full price of the damage caused by oil spills.

The NOAA is an arm of the U.S. Department of Commerce.

—By Mark A. Hofmann

Lloyd's

Continued from page 2

does not preclude members from suing auditors and other non-Lloyd's entities.

And the deadline for accepting the offer will not be extended beyond Feb. 14, Mr. Middleton said.

If the members reject the offer, "life goes on," he said. Lloyd's now has ample capacity to continue underwriting, and other business matters must be the focus of the market's executives, like increasing profits and forming a reinsurer to run off syndicates' old years, Mr. Middleton said (*BI* Aug. 30, 1993).

The failure of the offer would neither force Lloyd's to call a special levy when its predicted 1991 loss of 2 billion pounds ($2.96 billion) is announced in June nor force the market into insolvency, he said.

But Mr. Middleton warned members that the settlement is probably better than any verdict they will receive in court.

About half of the amount offered will not be available if members reject the offer and go to court, he said, since a maximum of only 560 million pounds ($842 million) is available in errors and omissions coverage if members win all their cases. And, the members will have to spend years in court trying to prove liability, recovering damages and enforcing the judgments before they see any money, he said.

However, many members already have made up their minds to shun the offer.

The 1,300-member Janson Green Action Group already has rejected Lloyd's offer. Members of Janson Green syndicates were slated to receive 12.9 million pounds ($19.4 million), or 1.4% of the offer (*BI*, Dec. 27, 1993).

Last week, two more action groups held public meetings and rejected Lloyd's offer, though the votes were not binding on individual members. They are:

- The 1,950-member Merrett Syndicate 418 (1985) Names Assn. Group, which in a show of hands voted 2-1 against acceptance. The Merrett 418 action group, which has no authority to vote on behalf of its members, previously conducted a survey of all 418 (1985) action group members. Of 925 members who responded, 72.1% said they would vote to reject the settlement, while 23.8% said they would accept.

Merrett syndicate 418 members account for 44.1 million pounds ($66.3 million), or 5%, of Lloyd's offer.

- The Poland Names Assn. voted against the offer by 148-3, according to a spokesman. The Poland syndicates account for 5.4 million pounds ($8.1 million), or less than 1%, of the offer.

Meanwhile, several members action groups have issued letters recommending that members oppose Lloyd's proposal.

The Cuthbert Heath Names Assn. and Devonshire Names Action Group committees sent letters Jan. 6 recommending that the settlement be rejected, said Alan Porter, chairman of both associations. The syndicates of these groups account for a total of 52.1 million pounds ($78.3 million), or 5.8%, of Lloyd's total offer.

And, late last week, executives of the Rose Thomson Young Action Group were hoping to mail a newsletter to advise members to reject the offer.

The entire RTY membership, including those in the action group, has been offered a total of 59.5 million pounds ($89.5 million), which is the third-largest settlement allocation after Gooda Walker and Feltrim. But the offer is not good enough, according to RTY Chairman Sir David Berriman.

"Your committee believes that the conditions attaching to this offer are weighted against the interests of names and that the offer falls short of what we might reasonably hope to recover in the High Court. Your committee cannot therefore recommend acceptance," he wrote.

Despite these rejections, however, London market sources believe that Lloyd's offer still could survive if members of The Gooda Walker Action Group and the Feltrim Names Assn. decide to accept it. But this scenario looks increasingly unlikely, they add.

The Gooda Walker Action Group is expected to reject Lloyd's settlement offer when it officially votes on it at a meeting today.

The action group's executive board already has recommended that the proposal be rejected by the members, said Richard Platts, the action group membership secretary. If the members vote to reject the offer, decision is binding on all 3,063 members of the action group, according to the group's constitution.

The action group constitutes 65% of the total number of members on Gooda Walker syndicates, he said. The entire membership of the Gooda Walker syndicates, excluding stop-loss syndicate 387, accounts for 209 million pounds ($314.2 million), or 23.2%, of Lloyd's offer. Syndicate 387 has its own action group.

Last week's announcement that the Gooda Walker syndicate losses have grown nearly 100 million pounds ($150.4 million) within a year has fueled the rejection of Lloyd's offer, he said.

G.W. Run-Off Ltd. informed Gooda Walker members last week that losses for six syndicates other than syndicate 387 grew nearly 13% to 835 million pounds ($1.24 billion) at the end of last year from 740.4 million pounds ($1.12 billion) at Dec. 31, 1992.

The growth in losses includes 52.7 million pounds ($79.8 million) for deterioration of accounts between 1986 and 1990, and an estimated loss of 41.9 million pounds ($62 million) for 1991, which closed at the end of last year under Lloyd's three-year accounting.

G.W. Run-Off estimates that total losses in a "worst-case scenario" for all Gooda Walker syndicates, excluding syndicate 387, will not exceed 1.1 billion pounds ($1.63 billion), provided there is no serious underreserving.

The Feltrim Names Assn. will meet Friday to discuss whether to reject Lloyd's offer. The action group members account for 187.4 million pounds ($281.8 million) of the 208.5 million pounds ($313.5 million) in Lloyd's offer allocated to Feltrim syndicate members, according to association Chairman Colin Hook.

Although "these are substantial sums of money by anyone's standards," the Feltrim association executive committee recommends that members vote against the offer, Mr. Hook said in a Jan. 7 letter to members. The committee believes that if members litigate, between 310 million pounds and 425 million pounds ($466.1 million and $639 million) is available from defendants, though "any monetary judgment is still likely to be a few years away," he wrote.

Therefore, "the amount offered (by Lloyd's) compares unfavorably with what we could hope to win for litigating names if the litigation continues," Mr. Hook wrote.

The offer also is flawed because members would have to give up all their legal rights relating to the syndicates, including any defense against future deterioration of claims, he said.

Mr. Hook warns members about the pitfalls of litigation: legal costs; erosion of errors and omissions coverage to pay damages; and the time required to collect any money paid once liability is decided.

Nevertheless, "in your committee's view, the amount offered is not enough to outweigh the risks and disadvantages of acceptance," he said. "Accordingly, your committee feels that it cannot recommend acceptance."

As with Gooda Walker, the Feltrim Names Assn. constitution gives the committee the power to vote on behalf of the entire membership. But Mr. Hook said the decision will be up to each individual Feltrim member in this case. The committee will abide by the individual votes of its membership.

Mr. Hook is one action group leader who believes there is still a chance that Lloyd's will amend the offer if it is clear that rejection is imminent, or even after rejection.

"Contrary to a number of assertions, no organization spends six to nine months trying to arrange an offer like this and that's just that. It's my personal view that there will be time and room to improve it structurally or mathematically," Mr. Hook said.

But Mr. Middleton is adamant that Lloyd's offer will not be changed. BI

Merger

Continued from page 1

plans to merge with competitor Qual-Med Inc. of Pueblo, Colo., with 350,000 HMO members (*BI*, Sept. 6, 1993).

Blue Shield of California called off plans to merge with Unihealth America, which holds a 51% stake in Pacificare Health Systems Inc. That merger would have created the second-largest HMO in California (*BI*, Nov. 8, 1993; July 5, 1993).

The FHP-TakeCare merger, which is expected to close during the second quarter of 1994, will not only create the second-largest HMO in California, but one of the largest in the Southwestern United States.

"This will position us as a Western-based" operation, said Jack Massimino, FHP's chief operating officer.

"These companies are stronger collectively than individually," said TakeCare Chairman Jack R. Anderson. "They uniquely complement each other—in terms of health care delivery systems, geography and mix of members—offering a greater opportunity to increase shareholder value."

"We expect the acquisition will have a positive effect on FHP's earnings in the fiscal year ending June 30, 1995, and have significant strategic advantages for company," agreed Dr. Robert Gumbiner, FHP's chairman.

The merger will be good for health insurance buyers, too, by providing seamless coverage to employers with operations throughout California and the West, an FHP spokeswoman pointed out.

"We want to compete for statewide accounts," but have been stymied by the lack of a statewide presence, she said. "This gives us the statewide presence to accommodate larger employers."

Merging also is expected to increase the firms' clout with providers.

HMOs "need more patients in their programs. The more business you can give a provider, the more leverage you have in negotiating (contract terms)," said Larry Tucker, a consultant with Hewitt Associates in Newport Beach, Calif.

The merged HMOs "will be a lot stronger together than either would be individually. The name of the game is volume. With volume, your leverage with providers becomes a lot greater," said Glenn Meister, a principal with A. Foster Higgins & Co. Inc. in Los Angeles.

Merging gives FHP "a lot more marketing clout," said John McHugh, a health care analyst with Kemper Securities Inc. in Chicago. "And by being able to market statewide, their competitive stance is significantly enhanced."

Others note that growth through acquisition makes a lot more sense in the highly competitive California HMO market than trying to build new networks in new areas from scratch.

For example, by acquiring TakeCare, FHP can avoid start-up losses that it was expected to incur by expanding on its own into Northern California and Colorado, Kemper's Mr. McHugh said.

The merger also will help FHP market its 24-hour coverage product, which combines health care coverage with workers compensation medical benefits, the FHP spokeswoman added. "The 24-hour product is doable only if that account has the HMO. This will double the market potential for our 24-hour product," she said.

By adding TakeCare's commercial HMO enrollment to FHP's total enrollment of 851,000, the merger also will enable the new company to market its Senior Plan to even more Medicare beneficiaries throughout the Southwest, points out Dave Briere, director of market development for TakeCare.

FHP, with 310,000 Medicare enrollees, was close to reaching a federal cap in some markets, an FHP spokeswoman confirmed.

Under federal law, Medicare enrollees cannot exceed 50% of a health plan's total enrollment population in a particular market.

In contrast, TakeCare, which currently has no Medicare enrollment, "was just on the verge" of introducing a Medicare risk product in Northern California, according to Mr. Briere.

The FHP/TakeCare merger reflects continuing consolidation in the health care industry.

"We're seeing consolidation across the health care sector," said Austin Broadhurst, a managing director of Russell Reynolds Associates Inc. of New York, an executive recruiting firm that specializes in health care.

"It's all part of the effort to develop scale and reduce duplicated costs in order to be competitive," he explained.

HMOs also have met increased competition from physician hospital organizations, groups of physicians who have banded together to form prepaid plans similar to HMO plans, said Mr. Broadhurst.

"Because of the growth of PHOs, which contract directly with payers. . .HMOs have to be cost-effective. . .justify their position in the food chain," he said.

"It shows that the industry is effectively anticipating the probable outcome of the Clinton administration's health reform efforts," said a spokesman for Health Net, which will be one of FHP's prime competitors with operations concentrated in California and Colorado after its merger with Qual-Med is completed.

And competition among health plans "is going to continue to heat up in the California marketplace," which is "predisposed to managed care," he predicted.

But Cheryl Pope, vp-operations in the Woodland Hills office of PruCare of California, said the move will make California's cut-throat managed care marketplace more rational.

"For us, it consolidates the competition," she said. "Before, we took both of them seriously. Now, we take one of them seriously. The fewer the competitors, the more rational the marketplace."

While FHP expects to eliminate any administrative redundancy created by the merger, there appears to be little duplication between the two organizations.

"We dovetail very well," said the FHP spokeswoman. "While TakeCare is strong in Colorado and Northern California, FHP is just starting up there. Also, TakeCare is in Ohio and Illinois; we're not. FHP is in New Mexico, Arizona, New Mexico, Utah and Guam."

As of Sept. 30, 1993, FHP's total enrollment was 851,000, including 433,000 in California; 162,000 in Utah; 159,000 in Arizona; 37,000 in Guam; 36,000 in New Mexico; and 24,000 in Nevada.

TakeCare, with enrollment of 742,000 as of Sept. 30, has 372,000 members in California; 290,000 in Colorado; 42,000 in Illinois and 38,000 in Ohio.

In California, the combined firm's enrollment of 1.6 million would be second only to the 6.6 million at Kaiser Foundation Health Plan Inc.

For the year ending June 30, 1993, FHP reported net income of $44.2 million on revenues of $2 billion. TakeCare, which operates on a calender year basis, earned $25.3 million on revenues of $615.2 million in 1992.

The acquisition agreement, which is subject to regulatory and shareholder approval, calls for FHP to pay $829 million, or $62 per share of TakeCare common stock. Payment will be made in the following form: 35% cash, including cash on hand and bank loans; 15% common stock; and 50% convertible preferred stock.

So far shareholders representing more than 25% of TakeCare's outstanding stock have indicated support for the merger.

TakeCare stock was trading at $58.88 per share late last week, while FHP stock was trading at $27.50 per share, both up in value following the announcement.

FHP, founded in 1961, is a diversified health care services company with 59 medical centers, two skilled nursing centers and three hospitals. In addition to its mixed-model HMO, FHP also offers indemnity health and life insurance and workers compensation insurance through Great States Insurance Co., a California-based insurer acquired in early 1993. At the time, FHP also picked up Skandia Benefit Services Co., a workers comp third-party administrator (*BI*, March 15, 1993).

TakeCare, founded in 1978, offers an individual practice association-model HMO in four states and a preferred provider organization nationwide.

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Jerry Geisel also contributed to this story.

S&P casts doubt on Bermuda cat facilities

NEW YORK—Standard & Poor's Corp. analysts are questioning the long-term survival of some of the Bermuda insurance and reinsurance facilities formed in recent years.

"S&P believes there is tremendous risk in the new ventures that are being formed in Bermuda," S&P Directors Paula Federman and Alan M. Levin conclude in an article in the S&P publication Focus.

"Some enterprises no doubt will be successful in the long run. But, unless favorable conditions prevail in the short run, many others may cease to exist. Still others may require rather large infusions of capital to continue doing business," the article states.

Many of the new companies are monoline writers of risky general liability, specialty liability or catastrophe coverages and are exposed to concentrations of low-frequency, high-severity losses, S&P notes.

Many are also insurers or reinsurers "of last resort" and have "little, if any, reinsurance or retrocessional capacity supporting them," the analysts say.

Even if the companies escape heavy losses on their business, they will also face pressure from their investors to diversify into new lines once the market for specialties like catastrophe reinsurance begin to soften, S&P predicts.

In the past, such diversification has produced sub-par financial results for insurers and security problems for policyholders, S&P says.

While the current Bermuda companies do not represent the kind of "naive capacity" that existed in Bermuda in the 1970s, "diversification is clearly the area where they could end up doing something stupid," Mr. Levin said. BI

Updates

Shares returned to pensioners

Continued from page 2

misappropriated by Mr. Maxwell. This month, Bank of America agreed to a $37 million settlement with plan trustees (*BI*, Jan. 10).

The Lehman Bros. unit has agreed with Robson Rhodes, joint liquidator of Bishopsgate Investment Management Fund, to hand back two block shareholdings in Lazard Property Unit Trust and Daily Telegraph P.L.C. worth just over 27 million pounds ($40.4 million).

Law firm fined for termination

NEW YORK—Baker & McKenzie, one of the nation's largest law firms, must pay the estate of a former employee more than $500,000 because it fired the associate when he was dying of AIDS.

The New York State Division of Human Rights also ordered Baker & McKenzie to pay Geoffrey Bowers' estate back pay—including the value of benefits, plus interest—from December 1986, when it fired him, until his death in September 1987.

The state agency found that Baker & McKenzie violated state anti-discrimination law when it fired Mr. Bowers. The $500,000 award for mental anguish is the largest ever ordered by the agency.

An attorney representing Baker & McKenzie said the firm did not know Mr. Bowers suffered from acquired immune deficiency syndrome when it fired him. Baker & McKenzie plans to appeal.

Prudential auditors sued

NEW YORK—Arthur Andersen & Co. and Deloitte & Touche have been named in a lawsuit charging that they helped Prudential Securities Inc. mislead investors in limited partnerships.

The suit, filed this month in California Superior Court in Orange County, seeks class-action status for more than 100,000 investors and seeks $1.1 billion in damages. It says the firms helped Prudential Securities inflate the price of partnership assets and disguise the repayment of investors' capital as distributions from revenues.

Prudential Securities, a unit of Prudential Insurance Co. of America, settled fraud charges brought by the Securities and Exchange Commission over the sales of limited partnerships (*BI*, Jan. 3).

An Andersen spokesman said the firm is "unaware of any factual basis for the lawsuit." A Deloitte spokesman could not comment.

Separately, the New York Insurance Department is investigating another Prudential unit for allegedly selling group pension contracts illegally. Prudential Asset Management Co. sold some contracts without the required prior approval of New York regulators and sold others that had been rejected, said Kevin Foley, deputy superintendent.

Briefly noted

The Supreme Court on Friday agreed to once again consider a **constitutional challenge to punitive damages.** The justices agreed to hear an appeal by Honda Motor Co. of a $5 million punitive award to a man injured when his all-terrain vehicle overturned. . . .The U.S. Supreme Court last week refused to review a ruling that **self-funded multiple employer welfare arrangements** are subject to state insurance regulation. The decision lets stand a ruling by the 2nd U.S. Circuit Court of Appeals (*BI*, Aug. 23, 1993). . . .**Aetna Life & Casualty Co.** would not comment last week on published reports that it may be preparing to sell off poorly performing units and to lay off thousands more people. . . .Dow Corning Corp. is taking a $415 million aftertax charge for its 1993 fourth quarter to account for potential liability in **breast implant litigation** and related costs. . . .The National Council on Compensation Insurance is seeking a 3.8% cut in the loss-cost portion of **workers comp rates in Maine** effective Jan. 1, largely because of 1993 system reforms (*BI*, Oct. 26, 1992). . . .**Nebraska Insurance Director William H. McCartney** plans to resign for personal reasons in the next several weeks. While he looks for another job, he will not take part in regulatory decisions involving individual companies. . . .Employees may defer a maximum of $9,240 to their **401(k) plans** this year, up from $8,994 in 1993. . . .The Los Angeles City Council voted not to contest liability in the $81 million civil suit filed in 1991 by **Rodney G. King,** provided a federal judge allows the city's motion to proceed immediately to a jury determination of damages. . . .Ringling Bros. & Barnum & Bailey Circus has "extensive insurance" to pay claims arising from a **train derailment** last week in which an elephant trainer and a clown were killed. The circus owned the 53-car train, which derailed near Lakeland, Fla. . . .The chairman and three other members of the Senate Environment and Public Works Committee have asked President Clinton to incorporate the recommendations of the **National Commission on Superfund** in his Superfund bill (*BI*, Dec. 27, 1993). . . .**The medical care component of the Consumer Price Index** increased 5.4% in 1993, down from 6.6% in 1992 and the lowest increase since 1973, but still double the overall rise in the CPI. . . .USAir Group Inc. must pay compensatory but not punitive damages for its negligence in allowing ice to build up on a jet that crashed at New York's La Guardia Airport in March 1992, a federal court in Cleveland ruled. The court still must determine damages (*BI*, March 30, 1992). . . .Medco Review Inc. of Orlando filed a complaint Jan. 6 with the Health Insurance Assn. of America, charging the University of Pittsburgh Medical Center with **violating health care billing guidelines.** Medco says the hospital is demanding that 100% of its bills be paid within 30 days and charging a fee for any bill audits. . . .**TIG Group Inc.** will appeal a $28 million punitive damage award by a Los Angeles Superior Court jury that found the insurer had acted in bad faith in failing to cover surety bonds on a Malibu construction project. . . .**Texas Eastern Transmission Corp.** may ask the 3rd U.S. Circuit Court of Appeals to reconsider a ruling denying coverage for a $750 million PCB cleanup because it failed to give timely notice of claims. The ruling replaces an unpublished decision by a three-judge panel of the 3rd Circuit (*BI*, June 7, 1993).

Cuomo

Continued from page 3

and most successful health care purchasing cooperatives in the nation," with annual premium increases over the past five years of less than 4%, he says.

"The elimination of NYSHIP will remove the current statewide pooling of risks which has generated a stable premium base. All plan participants from the smallest village in the Adirondacks to the largest county on Long Island pay the same premium for the plan's basic benefits package. . . .Should (the Clinton plan) result in more than one regional alliance within New York, this type of statewide pooling will cease to exist," Mr. Cuomo notes.

"We're a controlled plan that has provided 1.2 million people benefits very well for nine years, but under the current language of the (Clinton) plan, we'd be dismantled and thrown into an alliance. We'd end up subsidizing the alliance because our experience is so good," said Laura Balogh, director of New York's Civil Service Employees Assn. joint committee on health benefits.

The CSEA, with 200,000 active state and local government workers and 50,000 retirees, is the state's largest union of municipal employees, and its members have sacrificed pay increases in recent years for improvements in benefits that could be lost if NYSHIP is folded, said Ms. Balogh.

"The writing on the wall looks bad now because the government is committed to large alliances. But there's no way these alliances will be able to provide the benefits we do at an equal price," she said. "Some concession has to be made that allows us to keep the benefits we've earned without paying taxes on them because they exceed what the government's basic package calls for."

'The elimination of NYSHIP will remove the statewide pooling of risks which has generated a stable premium base,' Gov. Cuomo says.

Gov. Cuomo is speaking out against portions of the Clinton plan to alert state workers and New York's congressional delegation of some of the pitfalls in the Clinton plan, said Nelson Carpenter, director of employee benefits with the governor's Office of Employee Relations.

"Our plan is community-rated across the entire state and has posted below-average inflation for several years. It's comprehensive and offers wonderful benefits. There's no way an alliance with a different risk group can do as well. We suspect people in Washington will listen to the governor of New York. There must be more dialogue," he said.

Like Ms. Balogh, Mr. Carpenter said that there are two major problems with the Clinton plan. One is that large public entities like NYSHIP and private employer health plans will be treated differently.

The second is that the 7.9% payroll cap on benefits for private employers will adversely affect the state, which now spends about 9.7% of payroll on health care.

"By the year 2000, we'll probably be up to 10% or 11% and we won't benefit from the cap. General Motors will feel no pressure, but we will," said Mr. Carpenter.

"All public-sector employees, as taxpayers, will pay for subsidizing private-sector employees whose costs exceed 7.9% of payroll, yet no financial help is provided to public-sector employees," Gov. Cuomo's letter asserts.

The implementation of the Clinton plan would also foist some additional costs on New York state regardless of what benefits are included in the final benefits package or the details of the plan, according to the governor's Health Care Advisory Task Force.

According to the task force, in eliminating NYSHIP, the state would have to fund a one-time payment of $272 million for outstanding claims. And, if the state continued to provide current benefits exceeding the standard plan, costs would approach $200 million annually.

In response to Gov. Cuomo's criticism, Victor Zonana, an assistant deputy secretary in the Department of Health and Human Services, said the governor fails to point out in his letter any of the good things the Clinton plan could do for New York.

For example, "the plan would provide major subsidies for health benefits for early retirees. This should relieve the state of New York of a huge financial burden and would give them money to help pay the employees' share of premiums or supplement the basic benefits package."

"There's nothing being proposed for New York State workers that's not being proposed for members of Congress, the cabinet, the vice president or the president's family. We're cognizant that people will be with us and against us, but our feeling is what's good for us should be good for everyone, including New York's public employees," Mr. Zonana said. BI

AFL-CIO chief supports health care reform

WASHINGTON—After losing a bitter fight with President Clinton over the North American Free Trade Agreement, the leader of the nation's largest labor organization is throwing his undivided support behind the administration's health reform plan.

Claiming he knows of "no issue that is more important right now to the future of this country," AFL-CIO President Lane Kirkland said last week that he will urge unions to do "everything we can to develop the broad base of support required to get this measure through Congress."

"The successful enactment of good health care reform will affect virtually every issue that affects the country—from the problem of safe streets, decent cities, up to the general health and welfare of the population as a whole, our competitiveness internationally. Failure, on the other hand, would be an extraordinary missed opportunity."

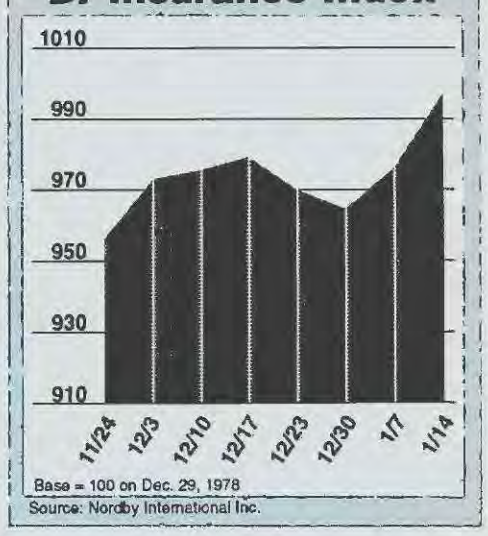
Only months ago, the union and the administration were locked in a bitter battle over NAFTA.

But Victor Zonana, an assistant deputy secretary in the Department of Health and Human Services, said the president had been banking on the support of the 14.5 million-member AFL-CIO.

"The AFL-CIO's unqualified endorsement is evidence that the workers of America, those people who strive and play by the rules, are serious about getting a comprehensive health plan in place that can't be taken away. To have fought this move would have been very short-sighted," Mr. Zonana said.

—By Michael Schachner

BI Insurance Index



Insurance stocks rose last week, as the *Business Insurance* Index gained 19.4 points to 995.3 Jan. 14 from 975.9 on Jan. 7. Advancing issues for the week were led by: TakeCare Inc., up 13.8%; Gainsco Inc., up 12.5%; and Lawrence Insurance Group, up 11.5%. Declining issues for the week followed: American Indemnity/Financial, down 12.5%; US Facilities Corp., down 7.2%; and Alexander & Alexander, down 6.1%. The most active issue was U.S. Healthcare, 4.6 million shares traded. The *BI* Index rose 2.0%; the Dow Jones 30 Industrials gained 1.2%; the NYSE Composite rose 1.0%; and the Standard & Poor's 500 rose 1.0%.

British Issues

Jan. 13 Companies	Price pence	P/E	Div. pence	Yield %	1 week High—Low pence	pence
Comml Union	665	N/M	29.6	4.5	678—	659
Genl Accident	723	N/M	33.6	4.7	738—	723
Gdn Royal Exch	217	N/M	9.0	4.1	233—	217
Royal	322	N/M	8.0	2.5	338—	322
Sun Alliance	393	N/M	17.6	4.6	409—	388
Brokers						
Bradstock	156	17.5	6.9	4.4	156—	155
CE Heath	412	19.8	20.0	4.9	418—	412
Hogg Group	166	18.5*	10.4	6.3	166—	166
JIB Group	133	18.0	9.5	5.2	183—	182
Lloyd Thmpson	301	20.2	8.4	2.8	301—	296
Lowndes Lmbrt	443	16.2	16.6	3.8	448—	444
PWS Holdings	81	12.0	5.0	6.2	81—	77
Sedgwick Grp	191	22.9	7.5	3.9	192—	186
Steel Brl Jones	136	N/M	15.0	11.0	136—	136
Willis Corroon	223	21.4	8.3	3.6	239—	228

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

JAN. 7, 1993 THROUGH JAN. 14, 1993

BROKERS		Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
Acordia Inc.	NYS	23.88	-5.45	-3.05	27.63	18.38	34	0.44	1.84	14	10.22	2.34
Alexander & Alexander	NYS	19.25	-6.10	-3.14	28.88	17.63	249	1.00	5.19	35	6.73	2.86
E.W. Blanch Holdings Inc.	NYS	18.88	0.00	8.63	23.50	16.50	12	0.32	1.70	18	4.10	4.60
Gallagher Arthur J. & Co.	NYS	33.88	-5.57	-5.24	37.38	25.50	105	0.72	2.13	17	7.52	4.50
Hilb, Rogal & Hamilton	NYS	12.38	1.02	-5.71	16.88	11.38	118	0.48	3.88	19	4.51	2.74
Marsh & McLennan	NYS	82.63	0.61	1.54	97.63	77.00	661	2.68	3.24	19	16.76	4.93
Poe & Brown	OTC	18.00	1.41	0.00	21.25	16.25	24	0.40	2.22	31	3.02	5.96
BROKERS	AVERAGE		-2.0	-1.0					2.9	22		
INSURERS/REINSURERS												
ACE Ltd.	NYS	30.00	0.84	-1.64	36.00	25.50	179	0.40	1.33	7	27.46	1.09
Acceptance Insurance Cos.	NYS	13.13	-0.94	12.90	15.63	8.25	58	0.00	0.00	15	9.65	1.36
AEGON N.V.	NYS	54.88	-2.01	0.23	58.50	43.25	22	1.22	2.22	11	34.71	1.58
Aetna Life & Casualty	NYS	56.88	1.11	-5.60	66.25	43.38	2108	2.76	4.85	20	71.84	0.79
Allied Group Inc.	OTC	26.25	-0.47	5.00	32.75	19.66	95	0.52	1.98	7	10.45	2.51
Allmerica Prop. & Casualty	NYS	63.00	-2.14	-2.51	66.50	51.50	41	0.48	0.76	5	56.97	1.11
Allstate Corp.	NYS	29.75	3.93	0.00	34.25	27.13	1266	0.72	2.42	14	18.43	1.61
American General	NYS	28.88	1.32	4.32	36.50	26.25	1826	1.08	3.74	11	22.09	1.31
American Heritage Life Ins.	NYS	19.75	3.27	6.04	25.34	17.25	32	0.60	3.04	13	12.42	1.59
American Indemnity/Fin'l	OTC	12.25	-12.50	-5.77	16.25	7.00	38	0.12	0.98	4	16.18	0.76
American International	NYS	85.38	0.59	-3.12	100.25	73.41	3111	0.40	0.47	15	45.25	1.89
American Re Corp.	NYS	31.00	10.71	9.73	41.75	25.75	836	0.00	0.00	26	14.80	2.09
Aon Corp.	NYS	47.88	0.00	-0.78	58.50	46.25	429	1.80	3.76	15	33.10	1.45
Argonaut Group	OTC	31.00	2.48	1.64	35.50	28.25	233	1.00	3.23	9	27.65	1.12
AVEMCO Corp.	NYS	19.50	-0.64	4.00	25.50	16.75	37	0.44	2.26	16	8.13	2.40
Baldwin & Lyons Inc.	OTC	15.75	5.00	5.88	16.25	11.16	2	0.20	1.27	12	12.59	1.25
Berkley W.R. Corp.	OTC	33.25	-1.85	1.53	50.50	32.00	759	0.40	1.20	12	28.12	1.18
Berkshire Hathaway Inc.	NYS	16700.00	0.91	2.30	17800.00	11350.00	0	0.00	0.00	-	8115.28	2.06
Chandler Insurance	OTC	5.50	0.00	0.00	5.88	3.50	8	0.00	0.00	13	8.87	0.62
Chubb Corp.	NYS	77.75	0.81	-1.11	96.38	75.13	1744	1.72	2.21	18	46.59	1.67
CIGNA Corp.	NYS	64.00	1.39	1.19	68.38	56.50	661	3.04	4.75	11	78.23	0.82
CNA Financial Corp.	NYS	78.00	3.83	-0.95	101.00	74.25	99	0.00	0.00	-15	77.92	1.00
Continental Corp.	NYS	27.25	1.40	-1.36	34.63	24.38	984	1.00	3.67	11	38.99	0.70
EXEL Ltd.	NYS	44.63	2.29	-0.83	52.25	42.25	563	1.20	2.69	7	33.81	1.32
Fremont General Corp.	NYS	24.13	1.05	0.00	28.75	21.00	242	0.72	2.98	8	23.40	1.03
Frontier Insurance Group	NYS	43.50	-0.29	-0.85	50.00	36.72	79	0.60	1.38	14	16.33	2.66
Gainsco Inc.	ASE	10.13	12.50	12.50	17.69	8.25	190	0.04	0.40	13	3.49	2.90
General RE Corp.	NYS	104.50	-0.48	-1.65	133.38	102.50	971	1.88	1.80	13	55.54	1.88
Guaranty National Corp.	NYS	18.38	5.00	5.00	24.75	16.75	37	0.48	2.61	10	11.81	1.56
Harleysville Group	OTC	27.50	-1.35	-3.51	32.75	22.63	32	0.64	2.33	14	18.35	1.50
Hartford Steam Boiler	NYS	48.63	6.87	9.27	59.88	42.63	305	2.12	4.36	57	15.80	3.08
HCC Insurance Holdings	OTC	30.50	0.00	0.83	35.75	16.50	201	0.00	0.00	21	14.94	2.04
Home Holdings Inc.	NYS	18.00	1.41	4.35	18.25	17.00	380	0.00	0.00	-	19.96	0.90
ITT (Hartford Group)	NYS	92.63	1.65	0.95	94.88	70.75	1095	1.96	2.12	-	57.11	1.62
Kemper Corp.	NYS	37.25	-2.30	3.83	43.00	26.13	550	0.92	2.47	-9	38.98	0.96
Lawrence Insurance Group	ASE	3.63	11.54	0.00	6.50	3.25	7	0.00	0.00	-	4.26	0.85
Liberty Corp.	NYS	25.50	3.55	3.03	34.75	23.75	421	0.56	2.20	10	21.44	1.19
Lincoln National	NYS	41.88	0.30	-2.62	48.25	34.69	976	1.64	3.92	9	32.53	1.29
Markel Corp.	OTC	40.25	0.00	4.55	40.50	32.25	30	0.00	0.00	11	24.68	1.63
Mid Ocean Ltd.	OTC	27.38	3.30	-3.10	34.75	25.00	538	0.00	0.00	15	20.24	1.35
Mutual Risk Mgmt. Ltd.	NYS	27.50	-2.65	-8.33	32.75	21.16	243	0.28	1.02	19	5.71	4.82
NAC Re Corp.	OTC	30.00	3.45	3.00	44.75	27.50	1293	0.16	0.53	16	19.24	1.56
National Re Corp.	NYS	28.38	-2.16	-7.35	39.63	27.50	135	0.12	0.42	9	16.89	1.68
Navigators Group	OTC	35.00	0.00	0.00	39.00	28.50	13	0.00	0.00	19	16.99	2.06
Nobel Insurance LTD.	OTC	8.31	0.76	9.02	8.44	6.00	58	0.00	0.00	3	6.84	1.22
NWNL Companies	NYS	33.13	2.32	1.92	38.75	25.38	274	0.80	2.42	13	23.97	1.38
Ohio Casualty Corp.	OTC	64.50	1.18	0.78	72.00	57.63	378	2.84	4.40	11	47.68	1.35
Old Republic Int'l	NYS	22.50	-0.55	0.00	27.63	21.50	471	0.44	1.96	9	23.57	0.95
Orion Capital Corp.	NYS	33.38	2.30	8.10	37.50	28.19	49	0.72	2.16	9	25.56	1.31
Phoenix RE Corp.	OTC	25.50	1.92	-7.27	38.25	17.00	973	0.28	1.10	-	19.99	1.28
Provident Life	NYS	30.50	0.00	-3.56	31.88	25.63	176	1.04	3.41	-11	26.38	1.16
Re Capital Corp.	OTC	14.00	4.67	2.75	16.25	13.25	13	0.28	2.00	15	16.88	0.83
Reliance Group Holdings	NYS	7.75	3.33	0.00	10.38	5.63	1092	0.32	4.13	3	4.22	1.84
RLI Corp.	NYS	27.38	-0.45	2.34	28.63	24.13	18	0.56	2.05	13	22.91	1.19
St. Paul Companies	NYS	85.88	-1.43	-4.32	98.00	75.00	425	2.80	3.26	-39	57.84	1.48
SAFECO Corp.	OTC	54.13	1.88	-0.92	66.75	51.88	1663	1.80	3.33	10	41.59	1.30
SCOR U.S. Corp.	NYS	12.88	-0.96	1.98	20.75	12.38	6	0.32	2.49	20	16.08	0.80
Seibels Bruce Group	OTC	1.69	0.00	-3.54	2.13	0.31	255	0.00	0.00	-1	1.90	0.89
Selective Ins. Group	OTC	30.38	0.83	0.41	31.00	20.50	52	1.12	3.69	21	23.11	1.31
Sphere Drake Holdings	NYS	17.88	6.72	8.33	21.63	15.50	104	0.12	0.67	19	N.A.	N.A.
Statesman Group Inc.	NYS	13.50	5.88	8.00	15.72	9.75	247	0.00	0.00	6	8.65	1.56
TIG Holdings	NYS	22.25	-3.26	-1.66	28.00	20.25	463	0.20	0.90	-9	18.49	1.20
Tokio Marine & Fire	OTC	56.13	2.98	3.94	67.00	46.13	36	0.37	0.66	-	57.72	0.97
Torchmark Corp.	NYS	45.38	0.28	1.40	64.75	41.13	560	1.12	2.47	13	17.35	2.62
Transatlantic Holdings	NYS	52.50	0.00	-1.64	61.50	49.00	205	0.36	0.69	14	29.60	1.77
Travelers Corp.	NYS	31.13	0.00	2.05	38.88	23.75	0	1.60	5.14	-8	33.35	0.93
Trenwick Group Inc.	OTC	37.00	-3.27	-4.52	49.75	37.00	403	0.88	2.38	11	26.00	1.42
United Fire & Casualty	OTC	36.00	-0.69	0.00	42.75	34.75	2	1.08	3.00	-	28.96	1.24
Unitrin	OTC	41.75	-1.76	-1.76	46.75	39.00	188	1.40	3.35	23	38.90	1.07
UNUM Corp.	NYS	52.88	0.24	0.71	60.13	47.75	584	0.80	1.51	14	27.55	1.92
US Facilities Corp.	OTC	11.25	-7.22	-5.26	14.00	6.50	43	0.00	0.00	10	10.48	1.07
USF&G Corp.	NYS	15.00	5.26	-0.83	19.63	12.38	1168	0.20	1.33	-	10.60	1.42
USLICO Corp.	NYS	16.88	3.05	2.27	20.00	15.00	43	0.24	1.42	-6	25.22	0.67
USLIFE Corp.	NYS	38.50	0.65	-0.65	45.75	35.75	156	1.24	3.22	11	41.73	0.92
Washington National	NYS	24.38	5.98	0.52	28.00	21.75	113	1.08	4.43	11	28.40	0.86
Zenith National Ins.	NYS	22.63	0.56	2.26	29.25	20.88	42	1.00	4.42	11	17.71	1.28
Zurich Reinsurance Centr.	NYS	26.63	-2.29	-5.75	36.38	26.25	241	0.00	0.00	-	24.41	1.09
INSURERS/REINSURERS	AVERAGE			1.1	0.9					2.0	4.2	
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	28.88	8.96	11.06	30.00	18.25	822	0.00	0.00	20	11.43	2.53
Pacificare Health Sys.	OTC	43.25	8.13	14.57	57.50	25.50	382	0.00	0.00	19	11.15	3.88
Safeguard Health Enter.	OTC	14.75	2.61	18.00	15.00	7.75	43	0.00	0.00	18	5.71	2.58
Sierra Health Services	ASE	25.00	7.53	12.36	25.00	11.50	283	0.00	0.00	19	4.60	5.43
TakeCare Inc.	OTC	56.88	13.77	8.03	60.00	25.75	1439	0.00	0.00	20	16.69	3.15
United Healthcare Corp.	NYS	80.25	4.05	7.36	80.25	40.00	935	0.00	0.00	36	10.64	7.54
U.S. Healthcare	OTC	60.38	5.69	5.00	60.63	36.75	4621	0.64	1.06	24	6.21	9.72
Wellpoint Health Networks	NYS	33.25	6.40	7.69	39.75	23.00	496	0.00	0.00	20	10.94	-
HMOs	AVERAGE			7.1	10.5					0.1	20	
ALL COMPANIES	AVERAGE			2.1	3.5					2.1	13	

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